

EXHIBIT K

Konstantin Walmsley, M.D.

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

- - -

IN RE: ETHICON, INC. : Master File
PELVIC REPAIR SYSTEM : No.
PRODUCTS LIABILITY : 2:12-MD-02327
LITIGATION :
_____ : MDL NO. 2327
:
MARY K. WARD, et al :
:
v. : CASE NO.
: 2:12-cv-02198
ETHICON, INC., et al. :
:

- - -

August 11, 2016

- - -

Expert deposition of
KONSTANTIN WALMSLEY, M.D., taken pursuant
to notice, was held at Courtyard Marriott
West Orange, 8 Rooney Circle, West
Orange, New Jersey, beginning at 9:03
a.m., on the above date, before Kimberly
A. Cahill, a Federally Approved
Registered Merit Reporter and Notary
Public.

- - -

GOLKOW TECHNOLOGIES, INC.
877.370.3377 ph| 917.591.5672
deps@golkow.com

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1 APPEARANCES:

2

3 MOTLEY RICE LLC

BY: HAYLEIGH T. STEWART SANTRA, ESQUIRE

4 28 Bridgeside Boulevard

Mt. Pleasant, South Carolina 29464

5 (843) 216-9373

hstewart@motleyrice.com

6 Representing the Plaintiffs

7

THOMAS COMBS & SPANN, PLLC

8 BY: SUSAN M. ROBINSON, ESQUIRE

(via telephone)

9 300 Summers Street

Suite 1380

10 Charleston, West Virginia 25301

(304) 414-1808

11 srobinson@tcspllc.com

Representing the Defendants Johnson &

12 Johnson and Ethicon

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I N D E X
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Testimony of: KONSTANTIN WALMSLEY, M.D.

By Ms. Robinson		8
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Walmsley (Ward)-2	Rule 26 Expert Report of Konstantin Walmsley, M.D.	6
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Walmsley (Ward)-4	Document Titled "Materials Reviewed"	6
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1 Walmsley Transcript of the 7
(Ward)-6 7/28/16 Deposition
2 of Geoffrey
DeLeary, M.D.

3
Walmsley Draft Transcript of 7
4 (Ward)-7 the 8/8/16
Deposition of
5 Robert Highland,
M.D.

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2 DEPOSITION SUPPORT INDEX

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5 Direction to Witness Not to Answer

6 Page Line Page Line Page Line

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9 Request for Production of Documents

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2 (Deposition Exhibit No.
3 Walmsley (Ward)-1, Notice of
4 Deposition of Konstantin Walmsley,
5 M.D., was marked for
6 identification.)

7 - - -

8 (Deposition Exhibit No.
9 Walmsley (Ward)-2, Rule 26 Expert
10 Report of Konstantin Walmsley,
11 M.D., was marked for
12 identification.)

13 - - -

14 (Deposition Exhibit No.
15 Walmsley (Ward)-3, 11/20/15
16 Curriculum Vitae of Konstantin
17 Walmsley, was marked for
18 identification.)

19 - - -

20 (Deposition Exhibit No.
21 Walmsley (Ward)-4, Document Titled
22 "Materials Reviewed", was marked
23 for identification.)

24 - - -

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1 (Deposition Exhibit No.
2 Walmsley (Ward)-5, 6/17/16
3 Encounter Summary for Mary Ward,
4 was marked for identification.)

5 - - -

6 (Deposition Exhibit No.
7 Walmsley (Ward)-6, Transcript of
8 the 7/28/16 Deposition of Geoffrey
9 DeLeary, M.D., was marked for
10 identification.)

11 - - -

12 (Deposition Exhibit No.
13 Walmsley (Ward)-7, Draft
14 Transcript of the 8/8/16
15 Deposition of Robert Highland,
16 M.D., was marked for
17 identification.)

18 - - -

19 KONSTANTIN WALMSLEY, M.D.,
20 after having been duly sworn, was
21 examined and testified as follows:

22 - - -

23 EXAMINATION

24 - - -

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1 BY MS. ROBINSON:

2 Q. Doctor, will you please
3 state your full name for the record?

4 A. Konstantin Walmsley.

5 Q. You understand that you're
6 under oath and you've sworn to tell the
7 truth here today just as if you were
8 sitting in a court of law; is that
9 correct?

10 A. Yes, ma'am.

11 Q. Doctor, you have been hired
12 by the Motley Rice firm in the case
13 involving Ms. Mary Ward; is that correct?

14 A. That's correct.

15 Q. And she was implanted with
16 the TVT mid-urethral sling device in June
17 of 2005; correct?

18 A. Yes.

19 Q. And that is an Ethicon
20 product; correct?

21 A. Yes.

22 Q. What were you asked to do
23 specifically with regard to Mrs. Ward's
24 case?

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1 A. I was asked to review
2 medical records relating to her care. In
3 addition, I was asked to perform an
4 independent medical examination of this
5 patient, and I was also asked to generate
6 a report based on my findings.

7 Q. And did you do that?

8 A. Yes, I did.

9 Q. When were you first
10 contacted by Motley Rice?

11 A. Originally, in early April.

12 Q. Early April and in 2016?

13 A. When you say contacted by
14 Motley Rice, are you regarding -- are you
15 talking about Mrs. Ward specifically or
16 about other work?

17 Q. That's a good question. So
18 with regard to Mrs. Ward specifically,
19 when were you first contacted by Motley
20 Rice?

21 A. That was probably more in
22 the late May to early June scenario,
23 somewhere around there.

24 Q. And you say, sometime in

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1 April, you were first contacted. Were
2 you first contacted by Motley Rice to
3 offer opinions involving mesh litigation?

4 A. That's the first time they
5 asked me to provide opinions regarding
6 Ethicon-based mesh litigation.

7 Q. Have you offered opinions
8 for Motley Rice in cases involving other
9 mesh products?

10 A. I have not.

11 Q. So has your testimony been
12 limited only to -- so far, has your
13 testimony been limited only to Ethicon
14 products?

15 A. With regards to Motley Rice,
16 yes, that's true.

17 Q. And have you offered expert
18 services for any other law firms suing
19 companies that manufacture mesh?

20 MS. SANTRA: I'm going to
21 object to the form as this is
22 general in nature and we're here
23 for the case-specific opinions on
24 Ms. Ward.

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1 THE WITNESS: Should I
2 answer the question?

3 MS. ROBINSON: Yes --

4 MS. SANTRA: You can answer.

5 MS. ROBINSON: -- go ahead
6 and answer the question, Doctor.

7 THE WITNESS: I'm sorry.
8 Yes.

9 BY MS. ROBINSON:

10 Q. And what other products have
11 you offered expert testimony about,
12 mesh-related products?

13 MS. SANTRA: Object to the
14 form.

15 THE WITNESS: Bard, Bard
16 Avaulta, and Bard Align TO; Boston
17 Scientific, I believe the Uphold
18 device, the AMS Elevate device --

19 BY MS. ROBINSON:

20 Q. Any others?

21 A. As I sit here today, I don't
22 recall any others.

23 Q. When did you first start
24 consulting as an expert in mesh

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1 litigation overall?

2 MS. SANTRA: I object to the
3 form. Susan, does this have
4 anything to do with Ms. Ward? I'm
5 going to have to at some point
6 instruct him not to answer.

7 MS. ROBINSON: Can he answer
8 that question?

9 MS. SANTRA: Sure.

10 THE WITNESS: I believe
11 roughly around 2013.

12 BY MS. ROBINSON:

13 Q. Doctor, part of my reason
14 for asking this question is because in
15 the past and currently, I've never been
16 provided with a list of the testimony
17 that you have provided in your cases, and
18 I keep trying to get counsel to provide
19 me with that list, but I don't have it.

20 Have you ever prepared a
21 list of the testimony that you have given
22 in the last four years?

23 A. Yes.

24 Q. Have you provided that list

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1 to Motley Rice?

2 A. Yes.

3 Q. Do you know why it was not
4 produced to me as a part of Mrs. Ward's
5 report?

6 MS. SANTRA: I object to the
7 form. Susan, I can get that for
8 you today.

9 MS. ROBINSON: Okay. If you
10 can e-mail that to me while we're
11 doing the deposition, that would
12 be great.

13 MS. SANTRA: Okay. I'll
14 have to...

15 BY MS. ROBINSON:

16 Q. So, Doctor, Exhibit No. 1 in
17 front of you is your Notice of
18 Deposition; correct?

19 A. Yes.

20 Q. And that's a familiar form
21 to you; is that correct?

22 A. Yes.

23 Q. And it requests that you
24 bring certain documents and records to

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1 the deposition. Did you bring anything
2 with you today?

3 A. The only thing I brought
4 with me today was my computer on which I
5 have most of the document requests you've
6 asked for in this form.

7 Q. Other than the medical
8 records that are listed on -- let me go
9 ahead and your -- Exhibit No. 2 in front
10 of you should be your report; is that
11 correct?

12 A. Yes.

13 Q. And on page 2 of your
14 report, it continues onto page 3, there
15 is a list of medical records you reviewed
16 in Mary Ward's case.

17 Do you see that?

18 A. Yes.

19 Q. Other than those medical
20 records, have you reviewed any other
21 materials in preparation for her -- I'm
22 sorry. Strike that. Let me reask that
23 question.

24 Other than these medical

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1 records, have you reviewed any other
2 medical records that you utilized to
3 formulate your opinions in Ms. Ward's
4 case?

5 A. I have reviewed some
6 additional medical records that were
7 provided to me by counsel.

8 Q. And what medical records
9 would these additional records be?

10 MS. SANTRA: I can -- I can
11 send you a link to the records
12 we've sent Dr. Walmsley, if that
13 is helpful.

14 MS. ROBINSON: When you say
15 "link," what are you referring to?

16 MS. SANTRA: A share file
17 link to the -- all the records
18 that we have sent Dr. Walmsley.

19 MS. ROBINSON: Okay.

20 BY MS. ROBINSON:

21 Q. And, Doctor, were -- these
22 additional records that you're talking
23 about today, were they received after you
24 wrote your report and formulated your

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1 opinions?

2 A. Yes.

3 Q. Did those medical records
4 that you reviewed after writing your
5 report change your opinions in any
6 respect?

7 A. No.

8 Q. Now, on page 3 of your
9 report, it lists that you reviewed the
10 depositions of Mary Ward and Jeffrey
11 Ward; correct?

12 A. Yes.

13 Q. Since writing your report
14 and formulating your opinions in this
15 case, have you reviewed any other
16 deposition testimony?

17 A. Yes.

18 Q. Have you reviewed the
19 deposition testimony of Dr. DeLeary?

20 A. Yes.

21 Q. And you understand he was
22 her -- the physician that implanted the
23 TVT device; correct?

24 A. Yes.

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1 Q. Did anything that you read
2 in Dr. DeLeary's deposition alter your
3 opinions in any way?

4 A. No, ma'am.

5 Q. Did anything you read in Dr.
6 DeLeary's deposition strengthen or weaken
7 your opinions in any way?

8 MS. SANTRA: Object to form.

9 THE WITNESS: No, not
10 especially.

11 BY MS. ROBINSON:

12 Q. When you say "not
13 especially," is there anything in
14 particular you have in mind when you make
15 that qualification?

16 A. Well, it was a little bit of
17 a broad question insofar as I'm thinking
18 of elements that were weakening or
19 elements that were strengthening; and I
20 definitely didn't find any elements that
21 would weaken it, but as I sit here today
22 and think about the other part of that
23 question, I don't specifically remember
24 any elements of that deposition that

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1 would have, let's say, galvanized a
2 particular opinion I put forth in my
3 report.

4 Q. Okay.

5 With regard to Dr. Highland,
6 have you had the opportunity to review
7 his transcript?

8 A. Yes.

9 Q. Did the deposition testimony
10 of Dr. Highland change or alter your
11 opinions in any way?

12 A. Not especially, no.

13 Q. And when you say "not
14 especially," again, what do you mean by
15 that qualification?

16 A. There weren't any particular
17 findings or passage in his deposition
18 that would lead me to say, to a
19 significant degree, well, maybe this
20 calls to question my opinion in my
21 report.

22 And the flip-side is true.
23 There was nothing in his deposition that
24 would otherwise have gone the other way

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1 around there.

2 Q. Have you read any other
3 deposition testimony --

4 A. I have not.

5 Q. Have you seen the expert
6 report of Dr. Matthews?

7 A. Yes.

8 Q. You did not file a rebuttal
9 to her expert report; is that correct?

10 A. That's correct.

11 Q. Other than, obviously, you
12 and Dr. Matthews disagree as to ultimate
13 opinions, was there anything in Dr.
14 Matthews' report that caused you specific
15 concern?

16 MS. SANTRA: Object to form.

17 THE WITNESS: No.

18 BY MS. ROBINSON:

19 Q. Exhibit 2, which is your
20 final report, does it contain all of your
21 opinions and the basis for those opinions
22 that you intend to give in this case?

23 A. Yes.

24 Q. Now, Exhibit No. 4 in front

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1 of you has been identified as your
2 reliance materials. Can you describe for
3 me just in general what that material is?

4 A. Yes. So it's a three-page
5 document listing materials reviewed, in
6 part depositions of medical providers and
7 also depositions of patients and perhaps
8 their spouses, instructions for use, the
9 plaintiff fact sheet, incorporated
10 materials, and then also about a
11 two-and-a-half-page list of medical
12 literature.

13 Q. Is there any specific
14 medical literature that you have
15 identified on Exhibit No. 4 that you
16 relied upon in Mrs. Ward's case?

17 MS. SANTRA: Object to form.

18 THE WITNESS: Well, I mean,
19 I really relied upon the whole
20 body of work, so -- I mean, if
21 you're asking me is there one
22 particular article that is by far
23 and away the one standout article
24 that I think strengthens Mrs.

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1 Ward's report, it would be hard
2 for me to identify just one
3 article.

4 BY MS. ROBINSON:

5 Q. Okay.

6 And another part of that
7 question I would ask you is whether there
8 is any one particular complaint or injury
9 that Mrs. Ward suffered that, in the
10 review of your material, that you relied
11 more upon one particular literature than
12 another?

13 MS. SANTRA: Object to form.

14 THE WITNESS: That's a bit
15 of a challenging question only
16 because I've never kind of had a
17 question like that posed to me in
18 that fashion.

19 And it's very hard for me as
20 I sit here today to point to one
21 or two articles that would
22 necessarily correlate with the one
23 particular symptom that I would
24 pick out as being the most

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1 compelling symptom based on the
2 literature.

3 And the reason I say that is
4 because, I mean, generally
5 speaking, as it relates to Mrs.
6 Ward, she has pelvic pain. She
7 has dyspareunia and she has
8 voiding dysfunction.

9 And the articles in my
10 reliance list, some of them focus
11 on mesh retraction. Some of them
12 focus on clinical complications.
13 Some of them focus on
14 mesh-specific properties such as
15 retraction and such.

16 So it's difficult for me to,
17 first off, point to one particular
18 complaint she has that I think is
19 the most compelling complaint and
20 then, second off, you know,
21 identify one, two, or three
22 articles that speak to that
23 particular complaint, because they
24 all kind of interweave as I form

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1 my opinions.

2 BY MS. ROBINSON:

3 Q. Doctor, when was mesh
4 retraction or contracture first reported
5 on in the medical literature?

6 MS. SANTRA: Object to form.
7 This goes to general opinion.

8 THE WITNESS: Well, that's a
9 very difficult question to answer,
10 because with regard to my
11 references, for example, many of
12 my references that discuss mesh
13 retraction date to a period of
14 time after 2009-2010.

15 That being said, I'm sure if
16 I was put to task, I could find
17 articles that go back to prior
18 times that describe mesh
19 contraction.

20 BY MS. ROBINSON:

21 Q. Doctor, are you aware of any
22 literature that describes mesh retraction
23 as early as the 1980s?

24 A. As we sit here today, I am

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1 not aware of that.

2 Q. Are you aware of any
3 scientific literature that reports upon
4 mesh retraction as early as the 1990s?

5 MS. SANTRA: Object to form.
6 This is general again.

7 MS. ROBINSON: Well, I'm
8 specifically asking you about your
9 reliance list and the material you
10 relied upon for Mrs. Ward's case,
11 and I believe that --

12 MS. SANTRA: You're asking a
13 very general question about what
14 literature came out in 1990.

15 MS. ROBINSON: You know,
16 there is no real prohibition about
17 me asking him general questions.
18 I mean, the prohibition is about
19 me going over material that he's
20 testified to ad nauseam on
21 multiple occasions. I don't and
22 haven't seen where he's testified
23 about this material.

24 So your objection, while I

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1 appreciate it, isn't -- you know,
2 just because it's a general
3 question doesn't mean it's
4 prohibited.

5 And, Doctor, I'm asking you
6 specifically whether physicians
7 who were implanting mesh as of
8 2005 would have known that mesh
9 retraction and contracture was
10 reported in the medical
11 literature.

12 MS. SANTRA: Object to form.
13 You can answer.

14 THE WITNESS: That's
15 obviously a different question
16 insofar as now we're dealing with
17 a different time period; correct?

18 MS. ROBINSON: Well, yeah,
19 but that's essentially what I'm
20 getting at. Okay?

21 BY MS. ROBINSON:

22 Q. And so let's step back again
23 and let me ask the question.

24 In the years of -- in the

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1 1990s, was mesh retraction reported in
2 the medical literature?

3 MS. SANTRA: Object to form.

4 THE WITNESS: You know, in
5 the 1990s, I was finishing medical
6 school and just about to, you
7 know, start my urology residency.
8 So certainly realtime back then,
9 it was not something I faced or
10 dealt with in clinical practice
11 and, you know, when I first
12 started using pelvic mesh for the
13 management of stress urinary
14 incontinence, which was in
15 2000-2001, my knowledge of mesh
16 retraction currently -- I mean, it
17 existed back then. It existed
18 primarily because my teaching
19 implanting surgeons and even key
20 opinion leaders who were at some
21 of the sling workshops I attended
22 described that there was a mesh
23 contraction process of about 10 to
24 20 percent depending upon the

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1 sling used.

2 So I don't know if that
3 answers your question as it
4 relates to is there medical
5 literature speaking to that, but
6 it was certainly common knowledge
7 to me in my training that this was
8 a phenomenon that not only
9 existed, but called for us to use
10 tension-free placement.

11 BY MS. ROBINSON:

12 Q. And you're a urologist;
13 correct?

14 A. Yes, ma'am.

15 Q. And your training was as a
16 urologist; correct?

17 A. With an additional year of
18 fellowship training that was female
19 urology-specific, yes.

20 Q. And do you have any reason
21 to believe that other urologists who were
22 performing stress urinary incontinence
23 surgical procedures would not have been
24 aware of the fact that there was mesh

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1 contracture and retraction in the year
2 2005?

3 MS. SANTRA: Object to form.

4 THE WITNESS: Well, I mean,
5 I can only speak for myself. This
6 was my breadth of education and
7 experience. You know, perhaps
8 there were other urologists that
9 looked at different medical
10 literature or had a different
11 basis of understanding, but it was
12 understood to me in that fashion.

13 BY MS. ROBINSON:

14 Q. And that the contracture
15 could be up to 20 percent?

16 A. Yeah, the description was
17 anywhere from 10 to 20 percent
18 contraction. That was really, to my
19 understanding, multifactorial. It wasn't
20 simply just the actual mesh itself
21 contracting. It wasn't the fact that the
22 polypropylene wasn't inert, but it also
23 related to wound healing and wound
24 contraction, which can cause a shrinkage

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1 effect as well.

2 Q. And has your understanding
3 about that changed in any respect up to
4 today?

5 A. To some extent, yes.

6 Q. In what way?

7 A. In that I didn't correlate,
8 at least not back in 2005, the mesh
9 retraction properties and their effects
10 on things such as vaginal pain.

11 Q. And is that the only way?

12 A. Also with overactive bladder
13 symptoms. It wasn't just pain, per se.
14 It was voiding dysfunction.

15 Q. Were you aware in 2000 and
16 -- 2000 and 2001 and 2005 that such
17 things as pain and voiding dysfunction
18 could be associated with the placement of
19 a TVT?

20 MS. SANTRA: Object to form.

21 THE WITNESS: Yes.

22 BY MS. ROBINSON:

23 Q. And so what you're telling
24 me is that you had not fully appreciated

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1 the mechanism of the mesh through the
2 contracture or retraction vis-a-vis the
3 pain and the overactive bladder; is that
4 what you're saying?

5 MS. SANTRA: Object to form.

6 THE WITNESS: I guess --
7 yeah, I guess what I'm saying --
8 and perhaps this is the same way
9 of saying it in different words --
10 is that inasmuch as I was aware of
11 the properties of mesh retraction,
12 I wasn't necessarily aware that
13 that particular process led to end
14 results, some of those end results
15 being pain and voiding
16 dysfunction.

17 BY MS. ROBINSON:

18 Q. But you were also aware --
19 while you were not specifically aware of
20 the properties, you were, in fact, aware
21 of the end result could be the risk of
22 implanting TVT would be pain as well as
23 voiding dysfunction; correct?

24 MS. SANTRA: Object to form.

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1 THE WITNESS: That was an
2 understanding of that surgery at
3 that time, that's correct.

4 BY MS. ROBINSON:

5 Q. So, Doctor, your C.V. is in
6 front of you and it's marked as Exhibit
7 No. 3?

8 A. Yes.

9 Q. And I believe it's dated as
10 of November of 2015. Do you have a more
11 recent C.V.?

12 A. I actually do have one that
13 I don't believe I've actually submitted
14 as yet, but I recently updated it, not on
15 the basis of my urological practice, but
16 on the basis of some of my
17 extracurricular activities.

18 MS. ROBINSON: And,
19 Hayleigh, I would request a copy
20 of his updated C.V.

21 THE WITNESS: I can do that.

22 MS. SANTRA: Sure.

23 BY MS. ROBINSON:

24 Q. Doctor, between the time

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1 period of November of 2015 up until
2 today, have you written any articles
3 regarding stress urinary incontinence?

4 A. No.

5 Q. Have you written any
6 articles regarding mesh?

7 A. No.

8 Q. Or polypropylene.

9 A. No.

10 Q. Have you written any
11 articles on pelvic floor dysfunction
12 whatsoever in that time period?

13 A. No.

14 Q. Are there any -- other than
15 you said some of your activities, are
16 there any other substantive materials or
17 work that you would have done between
18 November 2015 and today that reflect on
19 your expertise here testifying as a
20 urologist in a stress urinary
21 incontinence case?

22 A. No.

23 Q. Is your fee still \$500 an
24 hour for the work you perform?

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1 A. Yes.

2 Q. Have you submitted any
3 invoices in Mrs. Ward's case?

4 A. I have.

5 MS. ROBINSON: Hayleigh, can
6 I get a copy of the invoices that
7 have been submitted?

8 MS. SANTRA: Yes.

9 BY MS. ROBINSON:

10 Q. Can you give me an estimate
11 of how much time you've spent overall in
12 Mrs. Ward's case to date?

13 A. Yes, I can. I spent roughly
14 eight hours reviewing the initial salvo
15 of medical records and another roughly
16 three hours preparing the report; and
17 then in terms of my additional review for
18 this deposition, I've spent roughly an
19 additional three hours reviewing some
20 additional medical records, depositions,
21 and then Dr. Matthews' expert report.

22 Q. How long did the IME take?

23 A. Roughly 45 minutes.

24 Q. And I understand that you

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1 bill through your practice for that?

2 A. My practice bills for that
3 service, that's correct.

4 Q. Approximately how much does
5 that service cost?

6 A. \$350.

7 Q. Do you anticipate spending
8 any more time on Mrs. Ward's case until
9 such time as it may be set for trial?

10 A. Possibly in terms of
11 reviewing the deposition. That would be
12 the only additional work at this point I
13 could envision.

14 Q. And that's your own
15 deposition you're talking about. Right?

16 A. Yes, ma'am.

17 Q. Doctor, let's turn to
18 Exhibit No. 5, please.

19 A. (Witness complies.)

20 Q. That's your medical
21 examination of Mrs. Ward; is that
22 correct?

23 A. Yes, ma'am.

24 Q. And that is a five-page

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1 document?

2 A. Yes.

3 Q. Did Mrs. Ward fill out any
4 patient questionnaires before her
5 examination by you?

6 A. No.

7 Q. Did you make any handwritten
8 notes either of your review of her
9 medical records prior to writing your
10 report or during her medical examination?

11 A. I did not.

12 Q. Did Mrs. Ward bring any
13 documentation to her appointment with
14 you, either things like voiding diaries,
15 her medical records, anything of that
16 nature?

17 A. No.

18 Q. You examined her in your
19 office in New Jersey; is that correct?

20 A. Yes.

21 Q. She did not make any
22 complaints to you of having any
23 difficulty due to any physical
24 limitations or pain in traveling to North

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1 Carolina -- or from North Carolina to be
2 examined by you; is that correct?

3 MS. SANTRA: Object to form.

4 THE WITNESS: I don't
5 specifically recall such.

6 BY MS. ROBINSON:

7 Q. If she had made any such
8 complaints and they were relevant to her
9 mesh litigation, that's something you
10 would have noted in your medical exam
11 report; is that correct?

12 A. I would think so, yes.

13 Q. Before you saw her for your
14 medical examination, what material had
15 you reviewed in her case?

16 A. Nothing.

17 Q. You had not reviewed any of
18 her medical records before June 17th of
19 2016?

20 A. Generally speaking, what I
21 like to try to do -- I don't do this with
22 every patient, but I almost would prefer
23 to see them and perform the IME in the
24 absence of any medical records just so I

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1 could have a more innocent, if you will,
2 blank slate kind of opinion of the
3 patient.

4 Q. And you have a specific
5 recollection in this case you didn't
6 review anything before her examination.

7 A. I don't specifically
8 recollect reviewing records before this
9 particular individual, no.

10 Q. Can you tell me how the
11 examination is conducted? What happens
12 first and so forth?

13 A. Certainly. So the patient
14 comes to the office. There is an
15 inventory or intake of the patient
16 performed by my medical assistant.
17 During that time, the patient's pharmacy
18 information is taken, the medications
19 they're taking are recorded, vital signs
20 are measured, the past medical and past
21 surgical history is noted in the
22 electronic health record.

23 There is inventory of social
24 history, family history, and review of

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1 systems that's provided by my medical
2 assistant, and then the urine analysis is
3 also -- the dipstick, that is, is -- that
4 data is entered.

5 Once that's done, the
6 patient comes back to an examination room
7 and then I will come in and interview the
8 patient. During the interview, I,
9 generally speaking, document and record
10 as much information as possible and
11 certainly the information that I feel is
12 relevant.

13 After the interview is
14 completed and all the questions have been
15 asked, I step out of the room, have the
16 patient change, come back and perform a
17 chaperoned examination of the patient
18 that's documented and, in certain
19 instances, will also check the -- what's
20 called the postvoid residual of that
21 patient, in other words, how much urine
22 is left behind in their bladder after
23 they pee.

24 Following the physical

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1 examination having been performed, I then
2 complete the independent medical record
3 with an assessment and, if applicable, a
4 plan.

5 Q. You say, "if applicable, a
6 plan."

7 A. Correct.

8 Q. What do you mean by that?

9 A. Well, in a lot of instances,
10 when I see patients such as Mrs. Ward,
11 I'm not necessarily their treating
12 physician, so I don't necessarily
13 actively manage the problems they pose to
14 me.

15 Q. So the plan would be if you
16 have -- in the ordinary course of your
17 work, if you're seeing a patient that
18 you're treating, a plan would be what are
19 the next steps essentially.

20 A. That's correct.

21 Q. Could that plan include
22 follow-up testing in order to confirm
23 your preliminary diagnosis?

24 A. In certain instances.

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1 Q. And with regard to patients
2 that you're seeing as an expert, are --
3 do you formulate such a plan for them?

4 A. Usually not.

5 Q. So in Mrs. Ward's case,
6 would there be any follow-up testing that
7 you would recommend, that you did not
8 recommend, if she had been your patient?

9 MS. SANTRA: Object to form.

10 THE WITNESS: Not
11 necessarily.

12 BY MS. ROBINSON:

13 Q. And what's the qualification
14 you have on that?

15 A. Well, I mean, certainly
16 gaining more information on a patient can
17 be helpful in certain instances. So, you
18 know, for example, if a treating
19 physician taking care of Mrs. Ward
20 decided to, let's say, order a
21 urodynamics test or perform cystoscopy or
22 recommend that, I wouldn't necessarily
23 fault the physician for ordering that
24 type of test or evaluation.

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1 As it relates to me, I'm not
2 sure if either of those two tests as an
3 example would have led to either a change
4 in my opinion or, if I was actively
5 treating the patient, a change in my plan
6 of treating her.

7 So speaking for my own
8 personal instance as a treating
9 physician, which I'm not in this case, if
10 you're asking me if I would have ordered
11 those types of tests or any additional
12 tests, I probably would not have.

13 Q. Are there any tests that if
14 you were a treating physician that you
15 would have ordered for her?

16 MS. SANTRA: Object to form.

17 THE WITNESS: Not right
18 away, but possibly, yes.

19 BY MS. ROBINSON:

20 Q. And what possibly would you
21 have ordered later?

22 A. I might have found, for
23 example, in her, a urodynamics test to be
24 helpful.

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1 Q. And for what reason?

2 A. Well, one thing interesting
3 about Mrs. Ward is, she has fairly severe
4 incontinence and it's mixed incontinence.
5 She describes having urinary urgency
6 incontinence, but also stress
7 incontinence.

8 If conservative measures at
9 treating her incontinence were not to
10 work, a urodynamics test might help
11 explain the real nature of her voiding
12 dysfunction as far as, for example, which
13 type of incontinence predominates.

14 Q. You indicated she has severe
15 incontinence. How do you classify her
16 current complaints of incontinence as
17 severe?

18 A. So her incontinence is
19 severe to my mind on two findings, on two
20 bases: First off, it's a significant
21 quality of life bother for her. Second
22 off, it's different and worse, in fact,
23 than it was prior to her sling surgery by
24 account of the patient.

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1 Q. And when you say different
2 and worse by account of the patient,
3 you're saying, is that based solely upon
4 her description of her current
5 complaints?

6 A. Well, I guess it's about her
7 description and her relating that to me
8 and my documentation of such. I mean,
9 she told it to me in our IME that it was
10 worse and I believe she also stated that
11 in her deposition.

12 Q. But you have not done any
13 testing that would -- well, strike that.
14 Let me ask this question.

15 A. Sure.

16 Q. She had a cystoscopy prior
17 to her sling procedure in 2005; is that
18 correct?

19 A. Yes, she did.

20 Q. Did she have urodynamics at
21 that time as well?

22 A. Yes, she did.

23 Q. If you had performed those
24 two tests, is there any way in comparing

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1 those two tests that you would be able to
2 make an objective determination as to
3 whether her problems today are different
4 or worse than they were in 2005?

5 A. I think it's possible to do
6 that, yes.

7 Q. But that has not been done;
8 correct?

9 MS. SANTRA: Object to form.

10 THE WITNESS: Not by me, it
11 has not.

12 BY MS. ROBINSON:

13 Q. And how is it possible? Can
14 you please describe for me what might be
15 shown today if you were to perform those
16 two tests?

17 A. Well, obviously it's very
18 hard for me to know that since they've
19 not been done, but I mean, the way those
20 tests, if they were performed today,
21 could possibly be helpful is if they
22 showed different findings from what was
23 seen in 2005.

24 Q. And those findings could

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1 relate to showing you whether at this
2 point in time her overactive bladder
3 symptoms are worse today than what they
4 were in 2005; is that correct? Is that
5 one way?

6 MS. SANTRA: Object to form.

7 THE WITNESS: I think they
8 could help, but, you know,
9 urodynamics tests are a little bit
10 challenging because we're asking
11 -- what we're trying to do is
12 essentially recapitulate normal
13 bladder function in patients who
14 are essentially sitting on a
15 commode.

16 The only issue is, they're
17 sitting on a commode with
18 catheters in their urethras and
19 recti. They have patches on them.
20 They're being visualized, so it
21 can provide a lot of helpful
22 information.

23 But there are nuances to
24 doing the procedure that sometimes

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1 make the kind of comparison or
2 differentiation you're speaking of
3 somewhat more difficult to put
4 forth.

5 BY MS. ROBINSON:

6 Q. Okay. Let's go back to
7 Exhibit No. 5, please. Do I understand
8 then in looking at this report that
9 everything up to the HPI was information
10 that the patient provided to your
11 assistant?

12 A. Yes, with the exception of
13 medications. The medications are
14 automatically populated because of
15 electronic reviews of pharmacy
16 prescribing, so the medications are
17 auto-populated, but everything else is
18 provided by my medical assistant.

19 Q. And who was your medical
20 assistant in this case?

21 A. Quite frankly, I don't
22 remember who it was. It was one of three
23 people.

24 Q. When you look at page 1 of

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1 this report, under US, bladder, does that
2 reflect that an ultrasound was performed
3 of her bladder?

4 A. Yes.

5 Q. And that's something that
6 you performed yourself?

7 A. Yes.

8 Q. Did you do that after she
9 had voided?

10 A. Yes.

11 Q. How long after she had
12 voided?

13 A. Probably within about 15
14 minutes.

15 Q. And her postvoid residual is
16 15 milliliters; is that correct?

17 A. Yes.

18 Q. What does that show?

19 A. That shows that she empties
20 her bladder fairly well, very well.

21 Q. I'm sorry? I missed that
22 last part.

23 A. It indicates that she
24 empties her bladder very well.

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1 Q. And does that indicate to
2 you that she does not have any
3 obstruction of her bladder or urethra?

4 A. Not necessarily.

5 Q. Can you explain that to me?

6 A. Yes. So postvoid residual
7 can be really a reflection of two
8 different phenomena, one being the degree
9 of obstruction or restriction at the
10 level of the bladder outlet. The other
11 can be a reflection of bladder strength,
12 the muscular strength of the bladder that
13 allows the bladder to push fluid out.

14 Q. So with regard to
15 obstruction of the bladder outlet, is
16 that something that -- well, let me just
17 ask it this way: Based on your
18 examination of Mrs. Ward, does she have
19 obstruction of her urethra?

20 A. It's hard to answer that
21 question. I think it's possible.

22 Q. But you're not able to
23 testify to a reasonable degree of medical
24 certainty that Mrs. Ward's urethra is

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1 obstructed by the TVT; is that correct?

2 A. I would agree with that.

3 Q. With regard to her bladder
4 strength, are you able to say that --
5 well, what does this test tell you with
6 regard to her bladder strength, if
7 anything?

8 A. Well, it certainly indicates
9 to me that her bladder is not
10 underactive.

11 Q. Does it tell you anything as
12 to whether her bladder is overactive, the
13 postvoid residual test?

14 A. It can be part -- it can be
15 part of the data needed to confirm that,
16 yes.

17 Q. And does this amount of
18 postvoid residual show any indication
19 that she has overactive bladder?

20 A. It's supportive of that.

21 Q. How is it supportive of
22 that?

23 A. When I come across a patient
24 who has symptoms and/or signs of

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1 overactive bladder, for example, urgency
2 urinary incontinence, certainly seeing
3 urgency urinary incontinence in someone
4 who has a low postvoid residual as
5 opposed to a high postvoid residual is
6 more supportive and reflective of an
7 overactive bladder condition in the
8 proper clinical context.

9 Q. Is there anything else that
10 her postvoid residual -- any other
11 information that you gained from that
12 with regard to your diagnosis of her?

13 A. Yes. To some degree, yes.

14 Q. What else?

15 A. She does have a history of
16 recurrent urinary tract infections; and
17 on occasion, recurrent urinary tract
18 infections can occur in patients who
19 don't empty their bladder completely.

20 The fact that her postvoid
21 residual was low on this visit reflects
22 to me that that pathophysiology, if you
23 will, is probably not relevant here.

24 Q. Under her problem review, is

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1 this information that the plaintiff, Mrs.
2 Ward, told your medical assistant?

3 A. We're speaking about
4 reviewed problems on page 1?

5 Q. Yes.

6 A. Those are populated kind of
7 retrospectively, if you will, once the
8 assessment is populated. So the reviewed
9 problems are simply a reflection --
10 reflections of what's provided in the
11 assessment diagnoses, which are the last
12 two pages.

13 Q. Okay. Is that something
14 then that you would populate?

15 A. That's correct.

16 Q. And one of the things
17 reflected here is constipation; correct?

18 A. Yes.

19 Q. You agree with me that
20 constipation has been a complaint of Mrs.
21 Ward's for some time period.

22 A. Yes.

23 Q. Including before her surgery
24 with TVT in 2005; correct?

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1 A. Yes.

2 Q. And -- okay. Do you --
3 well, you are not testifying that TVT has
4 anything to do with her constipation;
5 correct?

6 A. No. That's correct.

7 Q. Do you agree with me that
8 constipation can cause pelvic pain?

9 A. Depending upon its severity,
10 yes.

11 Q. Do you agree with me that
12 the pelvic pain that can be caused by
13 constipation can be intermittent?

14 A. Yes.

15 Q. Do you agree that pelvic
16 pain that can be caused by constipation
17 can occur on and off over a number of
18 years?

19 MS. SANTRA: Object to form.

20 THE WITNESS: I think,
21 depending upon its severity, that
22 could happen.

23 BY MS. ROBINSON:

24 Q. Chronic cystitis is listed

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1 as well. Do you see that?

2 A. Yes.

3 Q. What is that intended to
4 represent here?

5 A. That's intended to be
6 reflective of the fact that this
7 patient's had recurrent urinary tract
8 infections.

9 Q. You do not relate that to
10 her TVT; is that correct?

11 MS. SANTRA: Object to form.

12 THE WITNESS: I -- actually,
13 I do.

14 BY MS. ROBINSON:

15 Q. Okay. Well, Doctor, I'm not
16 prepared to ask you questions about her
17 UTIs today.

18 A. Okay.

19 Q. And one of the reasons I'm
20 not going to do that is, nowhere in your
21 expert report do you say that her urinary
22 tract infection complaints are caused by
23 the TVT.

24 Do you agree with me on

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1 that?

2 A. I do.

3 Q. And I'm not going to ask you
4 those questions. Okay?

5 A. Okay.

6 Q. Dyspareunia, do you see
7 that?

8 A. Yes, I do.

9 Q. And that's something that
10 you've added in there and we'll talk
11 about that more later.

12 Pain in pelvis --

13 A. Yes.

14 Q. -- can you tell me what the
15 basis is for her -- this entry? I mean,
16 what's it based upon?

17 A. So when I examined her --
18 actually, I -- scratch that.

19 Before I examined her and I
20 started interviewing about her pain, she
21 described starting to have some pelvic
22 pain in 2010. Some of that pelvic pain
23 came as a result of intimacy. Sometimes
24 the pain occurred when she was not

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1 sexually active. Specifically, she
2 described having groin pain in both
3 groins, described as intermittent, dull,
4 sometimes worse after walking.

5 As you know, she actually
6 had her hysterectomy done in part because
7 of her pelvic pain. That surgery was not
8 helpful in resolving her pelvic pain.

9 Those are the bases for my
10 providing that as a diagnosis.

11 Q. Did you see anywhere in her
12 medical history where she had complaints
13 of pelvic pain other than in relation to
14 her hysterectomy?

15 A. Yes.

16 Q. Can you show me those
17 entries in your report?

18 MS. SANTRA: Object to form.

19 THE WITNESS: Let me take a
20 look.

21 (Pause.)

22 THE WITNESS: Could you
23 reread that question to me, Ms.
24 Robinson?

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1 MS. ROBINSON: I'll probably
2 rephrase it because I'm not sure
3 exactly how I asked it.

4 THE WITNESS: Okay.

5 BY MS. ROBINSON:

6 Q. But in your report, do you
7 identify any complaints that Mrs. Ward
8 made to any of her medical providers of
9 having pelvic pain other than the
10 instance prior to her hysterectomy where
11 she had reported a pelvic pain in her
12 lower left quadrant, I believe?

13 A. Well, I mean, I think, to be
14 fair, she had an underlying history of
15 constipation, which you and I have agreed
16 could be a source of pelvic pain -- am I
17 -- is that -- am I answering your
18 question to your satisfaction? I mean,
19 is that -- because to be fair, she did
20 have that as a problem before her sling
21 was ever done.

22 Did she ever say, "I'm
23 having pelvic pain from constipation"?
24 She did not. But I guess I'm trying to

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1 answer your question by saying, you're
2 asking me if she had any reason to have
3 pelvic pain prior to her sling and
4 that's, for example, one instance that
5 might explain why she might have had it
6 beforehand.

7 Have I seen her say, "I have
8 pelvic pain" or medical records
9 indicating that prior to her sling? I
10 have not seen that.

11 Q. Okay. And my question is
12 actually more specific as to up to today.

13 A. Okay.

14 Q. So let's break this out a
15 little bit.

16 One, you agree with me that
17 constipation could be a source of her
18 pelvic pain; correct?

19 A. Possibly.

20 Q. And you haven't been able to
21 rule that out as a -- to a reasonable
22 degree of medical certainty as a
23 potential source; correct?

24 MS. SANTRA: Object to form.

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1 THE WITNESS: I mean, it
2 would be very low on my
3 differential, but I wouldn't
4 completely rule it out, no.

5 BY MS. ROBINSON:

6 Q. Do we agree that she had
7 endometriosis?

8 A. She did -- she was diagnosed
9 with endometritis.

10 Q. And you're making a
11 distinction there between endometriosis
12 and endometritis? Or am I just
13 pronouncing that wrong?

14 A. It's just that when I think
15 of endometriosis, I think of a condition
16 where you can actually find depositions
17 of endometrial tissue in the pelvis; and
18 her diagnosis was, I believe, based on a
19 cervical biopsy, so I don't believe there
20 was any other tissues that were found to
21 contain endometritis.

22 Q. Okay.

23 Do we agree, however, that
24 that condition that she had can cause

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1 pelvic pain?

2 A. Yes.

3 Q. And you cannot rule that out
4 to a reasonable degree of medical
5 certainty as a potential cause of some of
6 her intermittent complaints of pelvic
7 pain; correct?

8 A. Up until her hysterectomy, I
9 cannot.

10 Q. And you also understand that
11 she had ovarian cysts; correct?

12 A. That's correct.

13 Q. And you agree with me that
14 ovarian cysts can cause pelvic pain;
15 correct?

16 A. Yes.

17 Q. Are you able to rule out the
18 ovarian cysts as a potential cause of her
19 pelvic pain?

20 A. Not entirely, no.

21 Q. So then my next question is
22 whether you have seen documented in her
23 medical records at any time up until
24 today complaints of pelvic pain that

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1 could not be attributed to one of those
2 three conditions, that being her
3 constipation, her endometrial tissue, and
4 ovarian cysts.

5 MS. SANTRA: Object to form.

6 THE WITNESS: Are we
7 excluding my IME from your
8 question?

9 MS. ROBINSON: Yes, because
10 I'm just asking about documents in
11 her medical records.

12 THE WITNESS: I'm just going
13 to ask you to ask that question
14 one more time, if you would, for
15 me.

16 MS. ROBINSON: Can I have
17 the court reporter read it back,
18 please?

19 - - -

20 (The court reporter read the
21 pertinent part of the record.)

22 - - -

23 MS. SANTRA: And I object to
24 the form.

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1 THE WITNESS: Yes.

2 BY MS. ROBINSON:

3 Q. Can you show me where that
4 is --

5 A. Well, one example of that
6 may be with Dr. Highland's office visit
7 which was in March of 2015 where she was
8 noted to have granulation tissue --

9 Q. Okay. Did -- were there
10 specific complaints of pelvic pain at
11 that time that you know of?

12 A. Well, once again, I mean,
13 there were intermittent complaints. I
14 don't recall in March of 2015 there being
15 pelvic pain and granulation tissue listed
16 in the same evaluation.

17 Q. Okay. Is that the only --
18 is that the -- is that office visit the
19 only other one that you have seen in her
20 medical records?

21 MS. SANTRA: Object to form.

22 THE WITNESS: Well, you
23 know, once again, I'm of the
24 understanding -- and this is

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1 obviously based on my discussions
2 with Mrs. Ward -- where that her
3 hysterectomy was done not only
4 because of vaginal bleeding, but
5 because of pelvic pain.

6 Other than what I've just
7 presented to you and the fact that
8 she's had some UTIs, some
9 left-sided pain, I'm going back to
10 2008 now, I'm not identifying any
11 specific pelvic pain issues in the
12 medical records that I've
13 received.

14 BY MS. ROBINSON:

15 Q. With regard to the March
16 23rd, 2015 visit with the granulated
17 tissue --

18 A. Right.

19 Q. -- do you agree that that
20 was not related to her TVT?

21 A. I don't have any evidence
22 that it was.

23 Q. What do you believe the
24 granulated tissue was caused by?

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1 MS. SANTRA: Object to form.

2 THE WITNESS: Probably
3 healing from the hysterectomy.

4 BY MS. ROBINSON:

5 Q. So, Doctor, the medication
6 list -- well, I'm sorry. Let's go on.
7 You have mixed incontinence
8 listed in the review of problems;
9 correct? And I'm back at Exhibit 5, your
10 examination here?

11 A. Yes.

12 Q. She had mixed incontinence
13 prior to her TVT; correct?

14 A. It was really almost purely
15 stress incontinence as a matter of fact.

16 Q. But there were documented
17 complaints in her medical records of
18 overactive bladder symptoms as well, is
19 that correct, by Dr. DeLeary?

20 A. Well, when she saw Dr.
21 Highland -- she did have urodynamics done
22 a few years prior seeing Dr. DeLeary
23 where a diagnosis of mixed urinary
24 incontinence was offered, and she also

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1 used Ditropan XL, which is a drug used to
2 treat overactive bladder.

3 That being said, when she
4 saw Dr. DeLeary, you know, his impression
5 was genuine stress urinary incontinence
6 related to urethral hypermobility.

7 Q. And as you're sitting here
8 right now, you don't recall seeing him
9 make notations of some kind of overactive
10 bladder.

11 A. What I recall is that he
12 prescribed Enablex, but soon thereafter
13 discontinued it when he operated on her,
14 which suggests to me that he wasn't
15 finding it or she wasn't finding it very
16 effective.

17 Q. Now, TVT is indicated for
18 the treatment of stress urinary
19 incontinence; correct?

20 A. Yes.

21 Q. It is not indicated for the
22 treatment of overactive bladder; correct?

23 A. Not directly, no.

24 Q. Some patients, however, who

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1 do have overactive bladder along with
2 stress urinary incontinence may see
3 improvement of both by the use of TVT; is
4 that correct?

5 A. That can happen sometimes,
6 yes.

7 Q. And it very well could have
8 happened with Mrs. Ward; is that correct?

9 MS. SANTRA: Object to form.

10 THE WITNESS: It's possible.

11 BY MS. ROBINSON:

12 Q. And you understand that for
13 an extensive time period, years, Mrs.
14 Ward did see significant improvement of
15 her urinary incontinence, is that
16 correct, with the TVT?

17 A. She did have some
18 improvement with her SUI, no question.

19 Q. And today, is it your
20 impression that her mixed urinary
21 incontinence is actually predominantly
22 overactive bladder?

23 A. The impression I got from
24 her was that it was about 50/50.

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1 Q. What caused her SUI in 2005
2 before her TVT placement?

3 A. Well, anatomically, she had
4 a condition called urethral
5 hypermobility.

6 Q. Did you do any testing
7 during your examination to confirm
8 whether she still has urethral
9 hypermobility?

10 A. Yes, I did.

11 Q. And what did you do?

12 A. One of the -- one of the
13 things I do during a pelvic exam when I'm
14 examining the patient is have them bear
15 down or cough to see if that produces any
16 prolapse.

17 Q. And what did you find when
18 you did that?

19 A. She did not have any
20 evidence of prolapse.

21 Q. So does that indicate she
22 had no evidence of urethral
23 hypermobility?

24 A. That's correct.

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1 Q. So is it your impression
2 that the TVT has worked to improve that
3 condition?

4 MS. SANTRA: Object to form.

5 THE WITNESS: It has
6 anatomically corrected the
7 hypermobility in my opinion.

8 BY MS. ROBINSON:

9 Q. Where did you report those
10 findings?

11 A. Well, since those are --
12 findings were not positive findings, I
13 didn't document the fact that she did not
14 have urethral hypermobility. In fact,
15 when I populate findings on my electronic
16 health resource, in a lot of instances,
17 if, for example, someone doesn't have
18 urethral hypermobility, it won't
19 necessarily add it there.

20 Some of them -- it'll
21 populate if there's no cystocele or
22 rectocele, for example. It'll say no
23 cystocele, no rectocele. So if you look
24 at my IME, it'll actually populate no

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1 cystocele, no rectocele. It doesn't,
2 however, populate no urethral
3 hypermobility. It only populates that in
4 a positive sense if it's there.

5 Q. I didn't even really see in
6 your report where you had done a cough
7 stress test.

8 A. Yes. Like, once again, I do
9 it on every woman who has incontinence as
10 a part of my practice, part of my
11 examination.

12 If the findings are
13 negative, it's not reflected in my
14 report. It's not reflected in my
15 physical exam because it's --

16 Q. What other type of negative
17 findings might you have that would not be
18 reflected in this exam note that we have
19 as Exhibit No. 5?

20 A. Well, for Mrs. Ward, there
21 were two negative findings that weren't
22 -- two positive findings that because
23 they were negative weren't noted.

24 One was that a lot of times

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1 when I'm doing a pelvic exam, if I
2 appreciate constipation, I'll document
3 that, so she had none of that, no
4 constipation.

5 And if the bladder is
6 palpable, oftentimes I will document the
7 bladder as being palpable. Her bladder
8 was not palpable.

9 Q. And what do you mean by the
10 bladder being palpable?

11 A. That I could palpate it even
12 after emptying, suggesting that perhaps
13 one is not emptying their bladder well.

14 Q. Okay. So when you examined
15 the bladder, you confirmed essentially
16 the postvoid residual finding that she
17 had normally emptied her bladder?

18 A. Right.

19 Q. Is there anything else that
20 didn't show up in your exam report that
21 was a normal finding?

22 A. None that I can think of
23 here today.

24 Q. So do I understand correctly

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1 then that based on your exam, she has had
2 an anatomical correction of her urethral
3 hypermobility?

4 MS. SANTRA: Susan, sorry.
5 Can we take a quick restroom break
6 or do you want him to answer --

7 MS. ROBINSON: Yeah, let him
8 answer that question first.

9 THE WITNESS: Could you
10 repeat the question, Susan?

11 MS. ROBINSON: Let's take a
12 break and we'll have the court
13 reporter read it back then.

14 THE WITNESS: Fair enough.
15 Thank you.

16 MS. SANTRA: Thanks. Sorry
17 about that.

18 (A recess was taken from
19 10:10 a.m. to 10:16 a.m.)

20 MS. ROBINSON: And if I can
21 just get the court reporter to
22 read that question back and then
23 we're ready to go.

24 - - -

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1 (Whereupon, the court
2 reporter read back from the record
3 as follows:

4 "QUESTION: So do I
5 understand correctly then that
6 based on your exam, she has had an
7 anatomical correction of her
8 urethral hypermobility?")

9 - - -

10 THE WITNESS: Yes.

11 BY MS. ROBINSON:

12 Q. Doctor, during -- did you
13 visually see any leakage during the cough
14 stress test?

15 A. I did not, although she had
16 very little in her bladder to leak out,
17 to be fair.

18 Q. But your objective findings
19 did not demonstrate any recurrence of her
20 stress urinary incontinence; is that
21 correct?

22 MS. SANTRA: Object to form.

23 THE WITNESS: Well,
24 unfortunately, they weren't really

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1 designed to demonstrate such, but
2 -- but, no, they did not.

3 BY MS. ROBINSON:

4 Q. Well, let me ask the
5 question again, because it's a very
6 straightforward question: Doctor, did
7 your objective findings on your
8 examination of the plaintiff, Mrs. Ward,
9 document a recurrence of her stress
10 urinary incontinence?

11 MS. SANTRA: Object to form.

12 THE WITNESS: No, they did
13 not.

14 BY MS. ROBINSON:

15 Q. Doctor, what -- assume for a
16 minute that Dr. DeLeary did note that he
17 saw components of overactive bladder and
18 that Mrs. Ward during her deposition
19 testimony said she did have some urge
20 symptoms prior to her TVT placement in
21 2005. Okay?

22 A. Okay.

23 Q. Just assume for me that
24 that's correct.

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1 A. Okay.

2 Q. Doctor, what would have
3 caused Mrs. Ward to have overactive
4 bladder symptoms prior to her TVT
5 placement?

6 A. Well, there are a lot of
7 different causes for overactive bladder.
8 So some of it is idiopathic. Sometimes
9 overactive bladder can be attributed to
10 lifestyle issues such as caffeine or
11 bladder irritant intake. There are
12 instances where, for example,
13 constipation, if it's severe, can
14 exacerbate overactive bladder symptoms.

15 Q. Anything else?

16 A. Well, weight can sometimes
17 be an exacerbating factor of overactive
18 bladder.

19 Q. Anything else?

20 A. None that I can think of as
21 we sit here today.

22 Q. Do you agree with me that
23 all of those factors exist in Mrs. Ward
24 today?

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1 A. To some degree they do, yes.

2 Q. Number one, her overactive
3 bladder symptoms could simply just be
4 idiopathic in nature; correct?

5 MS. SANTRA: Object to form.

6 THE WITNESS: Possibly.

7 BY MS. ROBINSON:

8 Q. Two, her overactive bladder
9 symptoms could be caused by her
10 lifestyle; correct?

11 MS. SANTRA: Object to form.

12 THE WITNESS: Possibly.

13 BY MS. ROBINSON:

14 Q. Did you see in her
15 deposition testimony that she drinks up
16 to three containers of tea a day?

17 A. Yes.

18 Q. Do you agree with me that
19 tea which contains caffeine can be a
20 bladder irritant?

21 A. Yes.

22 Q. And that that can cause
23 overactive bladder symptoms?

24 A. Yes.

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1 Q. Do you also see that she has
2 intake of six to eight glasses of water a
3 day as well?

4 A. Yes.

5 Q. And so you agree with me
6 that some of her lifestyle factors today
7 can impact her complaints of overactive
8 bladder; correct?

9 A. Not necessarily water
10 intake, but some of the other stuff we
11 discussed, yes.

12 Q. She still complains of
13 intermittent constipation as well;
14 correct?

15 A. Which she described to me as
16 mild, but yes.

17 Q. And if you look at your IME,
18 you've documented her current weight
19 today at, I believe it's, 232 pounds?

20 A. Yes.

21 Q. And, Doctor, assume for me
22 that one of her visits to Dr. Highland
23 documented that she weighed about 182
24 pounds before her TVT implant. That

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1 shows about a 50-pound weight gain; is
2 that correct?

3 A. Yes.

4 Q. Do you agree with me that
5 her weight gain can affect her urinary
6 functioning?

7 A. Yes.

8 Q. Do you agree with me that
9 weight gain can cause her to have urge
10 symptoms?

11 A. Yes.

12 Q. Do you agree with me that
13 her weight gain could even cause stress
14 incontinence?

15 A. Yes, to some degree, that's
16 true.

17 Q. Do you agree with me that
18 her 50-pound weight gain could make her
19 urge incontinence symptoms worse?

20 A. Possibly, yes.

21 Q. Did you recommend to her
22 that she loses weight?

23 MS. SANTRA: Object to form.

24 THE WITNESS: Not being her

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1 treating physician, we didn't
2 discuss that.

3 BY MS. ROBINSON:

4 Q. But it isn't surprising to
5 you that somebody who might have had some
6 slight overactive bladder symptoms in
7 2005, if they gain over 50 pounds ten
8 years later, continued to have caffeine
9 intake, it isn't surprising to you that
10 their overactive bladder symptoms could
11 worsen.

12 MS. SANTRA: Object to form.

13 THE WITNESS: I mean, in the
14 absence of all the other medical
15 nuances to Mrs. Ward and that this
16 was just a patient who did nothing
17 else other than gain 48 pounds and
18 continue along with her current
19 bladder irritant intake, is that
20 the question?

21 MS. ROBINSON: Yes.

22 THE WITNESS: It's
23 plausible, but -- but for Mrs.
24 Ward, it's a little more

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1 complicated than that, because she
2 has obviously mixed urinary
3 incontinence. It's not straight
4 urgency or overactive
5 bladder-related incontinence.

6 BY MS. ROBINSON:

7 Q. You also saw that she has
8 been diagnosed within the last few years
9 of having diabetes; is that correct?

10 A. Yes.

11 Q. How does diabetes affect
12 voiding?

13 A. Well, to a certain extent,
14 it depends on the duration of the
15 diabetes and one's hemoglobin A1C, which
16 serves as a fairly good indicator of
17 diabetic control.

18 So for patients who have
19 long-standing, poorly controlled
20 diabetes, sometimes what we see is
21 actually impaired bladder sensation where
22 the bladder doesn't feel itself to the
23 same degree it did in the nondiabetic
24 state.

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1 Q. And if that's the case, then
2 what impact does it have on somebody's
3 urinary function, their frequency, their
4 overactive bladder symptoms?

5 A. So, I mean, she's only
6 really had diabetes to my mind for the
7 last three years or so, so I'm not really
8 privy to her hemoglobin A1C levels. To
9 my -- you know, to my discredit, I
10 suppose, I didn't ask her that specific
11 question.

12 But assuming her hemoglobin
13 A1Cs were in poor control, it could have
14 a -- you know, it could have a minor
15 impact over three years, but nonetheless
16 an impact.

17 Q. And without -- you do not
18 have sufficient information right now to
19 rule the diabetes out as a potential
20 influence or a potential cause of her
21 overactive bladder symptoms; is that
22 correct?

23 A. Well, I would put minimal
24 weight on diabetes, but I wouldn't rule

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1 it out entirely.

2 Q. With regard to her
3 medications, did you review that list
4 with her?

5 A. Yes.

6 Q. Was she taking any pain
7 medications for complaints that she had
8 related to the TVT?

9 (Pause.)

10 MS. ROBINSON: I'm sorry.
11 Are you there?

12 THE WITNESS: I'm here. I'm
13 just trying to process the
14 question, because the pain that
15 she was relating to me was pelvic
16 and vaginal pain, including groin
17 pain.

18 And inasmuch as I was aware
19 of the fact that she was taking
20 multiple pain medications,
21 hydrocodone, for example,
22 meloxicam, for example, my
23 understanding is that she was
24 taking them for pelvic pain, but

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1 she didn't make mention to me that
2 she was taking them for other
3 purposes.

4 BY MS. ROBINSON:

5 Q. Well, if I told you she was
6 taking pain medications for her neck and
7 shoulder and back --

8 A. Uh-hum.

9 Q. -- would that be
10 inconsistent with your understanding of
11 what she -- what she presented to you?

12 A. Well, not necessarily, but
13 -- only because I was aware of her having
14 those conditions at the time of my IME.

15 That being said, I would
16 imagine that those medications, whether
17 they're being used for her back or neck
18 pain, were probably having some impact on
19 her pelvic pain.

20 Q. Are you testifying that the
21 pelvic pain that she experiences is so
22 severe that she has to take a pain
23 medication like hydrocodone to control
24 them?

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1 MS. SANTRA: Object to form.

2 THE WITNESS: Well, no, not
3 necessarily.

4 BY MS. ROBINSON:

5 Q. You've never seen a medical
6 record, a single medical record, where a
7 doctor has prescribed her with pain
8 medication for any complaints that she
9 has related to the TVT; correct?

10 MS. SANTRA: Object to form.

11 THE WITNESS: These pain
12 medications were not prescribed by
13 urologists, gynecologists, or
14 TVT-related doctors.

15 BY MS. ROBINSON:

16 Q. And, in fact, she has never
17 complained to a single doctor that she
18 has experienced pain during sexual
19 intercourse; is that correct?

20 MS. SANTRA: Object to form.

21 MS. ROBINSON: Other than
22 yourself.

23 THE WITNESS: No.

24 BY MS. ROBINSON:

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1 Q. Let me reask the question:
2 Is it correct that, according to your
3 review of your -- of her medical records,
4 that she has never complained to a single
5 one of her treating physicians that she
6 has experienced pain during sexual
7 intercourse?

8 MS. SANTRA: Object to form.

9 THE WITNESS: Could you
10 repeat the question? I'm sorry,
11 Susan.

12 BY MS. ROBINSON:

13 Q. Doctor, let me try to make
14 it simpler.

15 A. Okay.

16 Q. In your review of her
17 medical records, did you find anywhere
18 where she had made a single complaint to
19 any of her treating physicians that she
20 experienced pain during sexual
21 intercourse?

22 A. No.

23 Q. Doctor, if you'll turn to
24 page 4 -- well, first, let me -- let me

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1 -- before we do that, let's talk about
2 the review -- or her history of present
3 illness?

4 Did you find any
5 inconsistencies in her recitation of her
6 history to you with what you later
7 reviewed in the medical records?

8 A. I'm sorry. I don't know if
9 I understood that question, Susan.

10 Q. The history of present
11 illness, if I understand correctly, was
12 her providing you with that information
13 during your examination; correct?

14 A. That's correct.

15 Q. Did you later find any
16 inconsistencies with what she told you in
17 your review of her medical records?

18 A. Not especially, no.

19 Q. Up -- about five lines up,
20 you state: She notes bilateral groin
21 pain, intermittent, dull, sometimes after
22 walking.

23 A. Yes.

24 Q. Did you see anywhere in her

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1 medical records that she had made that
2 complaint to any of her treating
3 physicians?

4 MS. SANTRA: Object to form.

5 THE WITNESS: Yes.

6 BY MS. ROBINSON:

7 Q. Where did you see that?

8 A. As an example, in 2012, she
9 saw Dr. Highland with complaints of
10 left-sided pain, pelvic pain, which is in
11 the same region as the groin.

12 Q. Does that pain specify that
13 she's having that pain with walking?

14 A. No.

15 Q. Did I understand correctly
16 that that is pelvic pain that you related
17 to her ultimate surgery for the
18 hysterectomy?

19 A. To some degree, yes.

20 Q. Can you tell me how you did
21 the vaginal exam?

22 A. Yes. So my patients lie in
23 the prone position. They -- typically
24 I'll examine their abdomen first; and

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1 then when they undergo a pelvic exam,
2 they will either go into a position
3 called the frog leg where they bend their
4 legs in kind of a diamond shape or, in
5 this instance, they'll be positioned in a
6 lithotomy position where their legs are
7 up in stirrups.

8 At that point, I'll examine
9 them with -- do what's called a bimanual
10 exam, using gloves, whereby I separate
11 the labia to examine their external
12 genitalia, ask them -- first off, assess
13 the rugation or whether or not there's
14 atrophy to the vulvovaginal tissues,
15 examine for discharge, adequate
16 lubrication and such, and then perform
17 what's called a bimanual exam where I'll
18 insert my fingers into the vaginal canal
19 and ask them to bear down or cough to
20 assess if there's any prolapse.

21 During the bimanual exam,
22 there's also an opportunity for me to
23 palpate certain areas or trigger points
24 to see if there's pain to palpation.

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1 Q. At the time you were doing
2 this examination, you know that she is
3 complaining of having dyspareunia;
4 correct?

5 A. She had made that complaint
6 to me during her interview, yes.

7 Q. When you performed the
8 examination, did you use one digit or
9 two?

10 A. Typically, two.

11 Q. Did she describe that she
12 experienced any pain when you began the
13 examination just on insertion of the two
14 digits?

15 A. Prior to my insertion, she
16 had no pain.

17 Q. At what point did she
18 experience some pain?

19 A. Typically -- in her
20 instance, her pain was almost exclusively
21 in her anterior urethra, directly along
22 and under the sling, more so on the right
23 side than the left side.

24 Q. I guess I'm trying to get an

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1 understanding at what point in your
2 examination she would have had any pain.

3 A. Right. And I guess what I
4 -- maybe my answer wasn't clear before.

5 So when I placed my fingers
6 inside of her to examine her for
7 prolapse, I also would, you know, palpate
8 the vaginal canal throughout, the floor
9 of the vaginal canal, what's called the
10 apex or the uppermost portion of the
11 vagina and then what's called the
12 anterior vaginal canal underneath the
13 bladder and the urethra.

14 In her particular instance,
15 in terms of point tenderness and point
16 palpation, she had tenderness underneath
17 the sling in the area of the mid-urethra
18 with more tenderness up on the sidewalls
19 of the vaginal space. In Mrs. Ward's
20 instance, more in the right vaginal
21 sulcus than the left.

22 Q. And how did she express that
23 tenderness to you?

24 A. As I recall, that she would

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1 say, yeah, it's right there, it's --
2 that's where it hurts; and in terms of
3 the differentiator in terms of the
4 quantitative amount of discomfort, it was
5 -- it was more uncomfortable on the right
6 side than the left in the area of the
7 vaginal sulci.

8 Q. Was it so uncomfortable that
9 she could not endure your examination?

10 A. It was close to that point.
11 I mean, I didn't really mash the tissues
12 that aggressively, but I did it firmly
13 enough that she elicited -- that it
14 elicited pain.

15 Q. Did you notice any scarring
16 at the apex?

17 A. Nothing significant.

18 Q. Does that mean you didn't
19 notice scarring?

20 MS. SANTRA: Object to form.

21 THE WITNESS: Well, once
22 again, I think we're getting into
23 a discussion about documenting a
24 significant negative and whether

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1 or not, I guess, number one,
2 whether my computer would do that
3 for me automatically and whether
4 or not I would add that
5 information.

6 What I can tell you is, if
7 there was apical scarring, it was
8 insignificant enough that I didn't
9 feel it necessary to put in the
10 report.

11 If I were to re-examine her
12 today and you were to ask that
13 question and I was to examine her
14 realtime, I would probably have
15 said I can, you know, feel the
16 vaginal cuff scar if I felt it
17 closely enough. But was it a --
18 an excessive, thick, tender scar?
19 No.

20 BY MS. ROBINSON:

21 Q. Other than your notation
22 that she had tenderness under the
23 urethra, did she have -- were there any
24 other abnormal findings during your

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1 examination?

2 A. Yes. There was -- besides
3 induration, there was also a -- a taut
4 feeling to the sling in those particular
5 areas, where it almost felt as if the
6 edge of the sling felt more sharper and
7 more pronounced.

8 Q. But do I understand
9 correctly that there was no mesh
10 exposure; correct?

11 A. That's correct.

12 Q. You were unable to feel any
13 mesh underneath the scarring; correct?

14 MS. SANTRA: Object to form.

15 THE WITNESS: I could
16 palpate the sling underneath the
17 scar tissue, but I could not
18 appreciate, feel, or see any
19 extrusion.

20 BY MS. ROBINSON:

21 Q. She's never had any mesh
22 exposure or extrusion; correct?

23 A. Not to my knowledge, no.

24 Q. In your medical practice, is

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1 it uncommon for you to be able to feel
2 palpable mesh after a sling has been
3 placed?

4 MS. SANTRA: Object to form.

5 THE WITNESS: Somewhat.

6 BY MS. ROBINSON:

7 Q. But it is something that you
8 feel in cases; correct?

9 A. Yeah. If you're trying to
10 identify it and trying to feel it, in
11 most instances, you're able to.

12 Q. And when -- in those
13 instances, not all of those instances
14 reproduce pain; correct?

15 A. That's correct.

16 Q. Is it also true that if you
17 have placed a fascial sling for stress
18 urinary incontinence, that you can feel
19 where that sling has been placed after
20 the surgery?

21 A. That tends to be much more
22 challenging in my hands, but still
23 possible.

24 Q. Every surgical procedure for

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1 stress urinary incontinence has a risk of
2 scarring; correct?

3 A. Yes.

4 Q. And that risk of scarring
5 can be prevented only by not doing the
6 surgery; correct?

7 A. Yes.

8 Q. Can delayed healing increase
9 the scarring during -- after a stress
10 urinary incontinence surgery?

11 MS. SANTRA: Object to form.

12 THE WITNESS: I don't know
13 if I understand your question.

14 BY MS. ROBINSON:

15 Q. If there is a delay, if for
16 some reason the scar doesn't heal in the
17 ordinary process, can that create an
18 increase in the vaginal scarring?

19 MS. SANTRA: Object to form;
20 vague.

21 THE WITNESS: Yeah, I
22 suppose it depends on the cause of
23 the delayed healing, the
24 underlying issue related to that

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1 delayed healing, but that's a
2 plausible theory.

3 BY MS. ROBINSON:

4 Q. Did you see in the medical
5 records that a week after her surgery,
6 the plaintiff had a coughing fit and felt
7 pain and experienced bleeding from her
8 vagina after her surgery?

9 A. Uh-hum.

10 Q. You did see that; correct?

11 A. Yes, I did.

12 Q. Can that be something that
13 would interfere with her normal healing
14 process?

15 A. Well, you know, taking that
16 as a standalone question, I would say
17 yes, but I think her clinical history
18 would go against that in the instances of
19 that particular situation you're speaking
20 of.

21 MS. ROBINSON: Okay. Well,
22 move to strike everything after
23 "yes."

24 MS. SANTRA: Object.

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1 BY MS. ROBINSON:

2 Q. My follow-up question is,
3 does that indicate to you that there
4 might have been a little ripping or a
5 little tearing?

6 MS. SANTRA: Object to form.

7 THE WITNESS: No.

8 BY MS. ROBINSON:

9 Q. Is it possible that
10 following that event, that that event
11 could have caused greater type of
12 scarring for her than what otherwise
13 might normally have occurred?

14 A. I would say no to that.

15 Q. And what do you base that
16 on?

17 A. Well, I base that on the
18 lack of anything within the medical
19 records that would indicate that that
20 particular instance where she had this, I
21 guess, coughing spell and subsequent
22 bleeding spell -- there was nothing in
23 her post -- in evaluations following that
24 that indicated that she was having any

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1 sort of delayed healing or significant
2 scarring that would support that theory.

3 In fact, despite that, she
4 actually had, as we discussed, an
5 initially good result to her sling. So
6 it's just hard for me to imagine that
7 something happening on June 27th, 2005,
8 with a follow-up approximately nine days
9 later on July 6th where the vaginal
10 bleeding had stopped that same day and
11 she had no further problems or pain -- of
12 pain or discomfort, you know, voiding
13 well, denying any leakage, it's hard for
14 me to state that that would have been a
15 risk factor for either delayed healing or
16 excessive scarring or any other
17 complication.

18 Q. Doctor, during your
19 examination, she had a normal urinalysis;
20 is that correct?

21 A. Well, with the exception of
22 glycosuria, yes. She had sugar in her
23 urine.

24 Q. And that's consistent with

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1 her diabetes; correct?

2 A. Yes.

3 Q. Is that an abnormal level of
4 sugar?

5 A. That is.

6 Q. How high is that?

7 A. Well, typically, for someone
8 to spill sugar in their urine, their
9 blood sugar has to be over 180. So I
10 can't comment as to the specific blood
11 sugar level, but it's suggestive of the
12 fact that her sugar was not adequately
13 controlled at the time of her visit to
14 me.

15 Q. Under your assessment and
16 plan, when you talk about pain in pelvis,
17 pelvic and perineal pain --

18 A. Correct.

19 Q. Do you see that?

20 A. Yes.

21 Q. -- did she experience pain
22 in the perineal area during your
23 examination?

24 A. No.

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1 Q. Where does that come from?

2 A. That is an ICD-10 code that
3 unfortunately groups pelvic pain under
4 the nomenclature of pelvic and perineal
5 pain.

6 Q. So she -- are you saying she
7 did not have any peroneal pain and that's
8 just an electronic entry?

9 A. Yes, ma'am.

10 Q. Doctor, I'm still a little
11 confused about the pelvic pain
12 complaints. Are those complaints
13 distinct from the dyspareunia complaint?

14 A. Yes, they are.

15 Q. Was there anything on your
16 examination that had -- supported any --
17 you know, any of her symptoms of pelvic
18 pain other than the dyspareunia?

19 A. Well, I mean, the pelvic
20 exam, to be fair, didn't demonstrate
21 dyspareunia. It just provoked pain on
22 vaginal exam. So certainly vaginal pain
23 was reproducible. The vaginal pain that
24 was produced on exam was consistent with

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1 where she had had dyspareunia.

2 But regarding pelvic pain,
3 it really only was borne out during my
4 interview with the patient. I wasn't
5 able to re-create, for example, groin
6 pain on examination.

7 MS. SANTRA: Off the record.

8 - - -

9 (A discussion off the record
10 occurred.)

11 - - -

12 BY MS. ROBINSON:

13 Q. Doctor, I think you were
14 describing during your examination you
15 were not able to reproduce any groin
16 pain; is that correct?

17 A. That's correct.

18 Q. And with regard to pelvic
19 pain itself, did I understand correctly
20 on what you were saying that while your
21 examination showed some tenderness, that
22 isn't necessarily indicative of somebody
23 in her daily activities experiencing
24 pelvic pain?

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1 A. To some degree. So, for
2 example, my physical exam demonstrated
3 some of the pelvic pain that Mrs. Ward
4 had, but not all that was described to
5 me, and I'm not convinced that the pain
6 she has at rest that's worsened by
7 walking is necessarily the vaginal pain
8 that I reproduced on exam.

9 Q. Are you testifying to a
10 reasonable degree of medical certainty
11 that the pain that she describes upon
12 walking is caused by the TVT?

13 A. I wouldn't attribute it
14 solely to the sling, no.

15 Q. And what's the basis that
16 you attribute it partially to the sling?

17 A. Well, the placement of the
18 sling is -- is in the area of her pain,
19 so I wouldn't rule it out because of
20 that.

21 Q. Would you agree with me the
22 literature does not support incidences of
23 groin pain following TVT surgery?

24 MS. SANTRA: Object to form.

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1 THE WITNESS: Well, I don't
2 know if I would necessarily agree
3 with that, because I think it also
4 depends on the route of placement.
5 I mean, in other words, a TVT
6 Obturator sling has a higher risk
7 of groin pain than a retropubic
8 TVT sling, for example.

9 BY MS. ROBINSON:

10 Q. And she has the retropubic;
11 correct?

12 A. That's correct, yes.

13 Q. With regard to her
14 dyspareunia, what does your examination
15 tell you -- or how does your examination
16 play in your assessment that her
17 dyspareunia is caused by the TVT?

18 A. Well, it's a combination
19 both of her subjective complaints and
20 objectively what I discovered. To be
21 fair, she had only had sex with her
22 husband about three or four times and, in
23 fact, hadn't been sexually active after
24 her hysterectomy, but she describes

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1 specifically that the pain being pain in
2 the vaginal canal and in the groin area.

3 Taking her groin pain out of
4 the equation relating to her dyspareunia,
5 when I examined her, the pain that I was
6 able to reproduce on exam corroborated
7 with the physical location of the pain
8 that she had during intimacy, and when I
9 say the pain in her vaginal canal is what
10 I'm speaking towards.

11 Q. And how did it corroborate?
12 Did it corroborate in terms of location?
13 Did it corroborate in terms of intensity?

14 A. Probably more location, you
15 know, than intensity; and, I mean, I
16 don't want to sound graphic here, but
17 it's difficult to reproduce, you know,
18 vaginal intercourse-related pain during a
19 bimanual exam obviously.

20 Q. Okay.

21 So then how do you know that
22 the location is consistent with the pain
23 she would experience during sexual
24 intercourse?

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1 A. So, I mean, to the point of
2 dyspareunia or vaginal pain, I guess
3 there are two elements. One is that --
4 the quality of the pain and the other is
5 the location, I suppose. And the quality
6 can have its own breakdown I guess as to
7 particular elements.

8 But when I was examining
9 Mrs. Ward, for example, and reproducing
10 tenderness on exam, she recounted to me
11 that the pain that she was having during
12 my vaginal exam was the same
13 location-wise as the pain she had during
14 intimacy, during intercourse.

15 Q. So it's based on her telling
16 you that when you touched her in a
17 certain area, that was the area she was
18 having pain during sexual intercourse.

19 A. It may have been the other
20 way around. It may have been more me
21 examining her and eliciting tenderness
22 and saying, is this where you were having
23 pain when having sex, when having
24 intercourse, to which she recounted yes.

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1 Q. Did you take any measures to
2 account for the fact that she's in
3 litigation?

4 MS. SANTRA: Object to form.

5 THE WITNESS: I did not.

6 BY MS. ROBINSON:

7 Q. And you understand that pain
8 is pretty much subjective. Right?

9 MS. SANTRA: Object to form.

10 THE WITNESS: I mean, I
11 think pain has certainly different
12 layers of quality and
13 significance.

14 BY MS. ROBINSON:

15 Q. Did you find anything during
16 the course of your examination that you
17 felt would prevent her from having sexual
18 intercourse?

19 MS. SANTRA: Object to form.

20 THE WITNESS: Well, I think
21 the term "prevent," it probably
22 has multiple layers, too. Are you
23 speaking about kind of
24 mechanically?

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1 MS. ROBINSON: Yes.

2 MS. SANTRA: Object to form.

3 THE WITNESS: I mean, with
4 the exception of the scar tissue
5 and the tenderness to it around
6 the area of her sling, no.

7 BY MS. ROBINSON:

8 Q. Speaking specifically about
9 the scar tissue and the tenderness, are
10 you able to testify that that in and of
11 itself is significant enough to prevent
12 sexual intercourse?

13 A. Well, this is one of these
14 areas where we have to kind of jump from
15 one particular arena to the other.

16 So I'm understanding through
17 an interview and exam with this patient
18 that it's painful, so kind of the
19 pre-answer premise to your question is
20 that intimacy is so painful for her that
21 she doesn't want to have it.

22 That being said, could an
23 average-sized -- not to be graphic, but
24 an average-sized penis be inserted into

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1 her vagina? I would say the answer to
2 that would be yes.

3 Q. You have treated -- well,
4 have you treated patients who come to you
5 and do not have sex because they have
6 pain during sexual intercourse?

7 A. Yes.

8 Q. And is it fair to say that
9 many of those patients have never had a
10 TVT sling placed?

11 MS. SANTRA: Object to form.

12 THE WITNESS: Some of them,
13 yes.

14 BY MS. ROBINSON:

15 Q. Is it fair to say that, you
16 know -- well, I'm not talking about the
17 TVT sling. I'm talking about any sling.

18 A. Right.

19 Q. Okay.

20 And in those instances, are
21 they there so that you can help them have
22 more comfortable sexual intercourse?

23 A. Yes.

24 Q. And what is it that you

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1 recommend that they do?

2 A. Well, it depends on what's
3 causing the dyspareunia.

4 Q. And there are many different
5 potential causes of dyspareunia; correct?

6 A. There are -- there are
7 multiple causes.

8 Q. And, for example, can you
9 tell me that on the one or two occasions
10 that Mrs. Ward had attempted sexual
11 intercourse with her husband, that her
12 pain was not caused by either her -- the
13 ovarian cyst she had or the endometrial
14 problems that she has?

15 MS. SANTRA: Object to form.

16 THE WITNESS: Well, I can
17 speak to you about my discussions
18 with her and what she recounted to
19 me.

20 MS. ROBINSON: Well -- okay.
21 Go ahead and do that.

22 THE WITNESS: So it was a
23 number -- it was a number -- she
24 had sex about three or four times.

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1 She described the pain as being in
2 both the vaginal canal and in the
3 groins; but when she described it
4 based on her husband's experience,
5 she felt like he was placing a
6 rough stick inside of her with
7 more pain on the right than the
8 left.

9 BY MS. ROBINSON:

10 Q. Do you know whether that was
11 consistent with her deposition testimony
12 or not?

13 A. I don't specifically recall
14 location language in her deposition. I'd
15 have to re-look at it again to see.

16 MS. ROBINSON: Okay. We'll
17 move on.

18 Can I get an idea of how
19 much time I have on the record
20 left?

21 - - -

22 (A discussion off the record
23 occurred.)

24 - - -

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1 THE COURT REPORTER: Eight
2 minutes left.

3 MS. ROBINSON: So I will
4 stop here at 11:10. Okay. So,
5 Doctor, let me move on a little
6 bit.

7 BY MS. ROBINSON:

8 Q. On page 2 of your report,
9 which is Exhibit 2, you list a number of
10 common complications with TVT; is that
11 correct?

12 A. Yes.

13 Q. Do we agree that you are not
14 relating pain into her legs or thighs to
15 the TVT; correct?

16 A. Correct.

17 Q. Do we agree that she does
18 not have chronic inflammation of her
19 tissue?

20 A. I would disagree with that.

21 Q. You didn't perform a biopsy.
22 Right?

23 A. I did not.

24 Q. She never had her mesh

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1 explanted; correct?

2 A. That's correct.

3 Q. Did you visualize any
4 discharge from her vagina during your
5 examination?

6 A. I did not.

7 Q. Did you visualize -- did you
8 use a speculum during your examination?

9 A. I did.

10 Q. Did you visualize any
11 redness or inflamed areas around her
12 urethra?

13 A. I did not.

14 Q. Doctor, you didn't find any
15 scar bands; correct?

16 A. I did not.

17 Q. There was no vaginal
18 shortening or stenosis; correct?

19 A. Not that I identified, no.

20 Q. There was no erosion or
21 exposure or protrusion of her mesh; is
22 that correct?

23 A. No, ma'am.

24 Q. You did not find any nerve

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1 entrapment; correct?

2 A. No.

3 Q. There was no roping or
4 curling of her mesh; is that correct?

5 A. No.

6 Q. There was no fraying;
7 correct?

8 A. That's correct.

9 Q. There was no particle loss
10 that you found; correct?

11 A. None that I could identify,
12 no.

13 Q. There was no infection of
14 her wound or infection of the site of her
15 mesh; correct?

16 A. No.

17 Q. Do you know if her TVT was
18 mechanically cut or laser cut mesh?

19 A. I do not know.

20 Q. As a result of that, is it
21 fair for me to say, Doctor, you cannot
22 attribute any of her injuries to the fact
23 that her mesh was either one or the
24 other?

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1 MS. SANTRA: Object to form.

2 THE WITNESS: That's

3 correct.

4 BY MS. ROBINSON:

5 Q. And there was no degradation

6 of her mesh. Do we agree with that?

7 A. None that I could identify.

8 Q. Doctor, with regard to your

9 general opinions regarding the IFU,

10 you've never written an IFU; is that

11 correct?

12 A. I have not.

13 Q. You've never worked for a

14 device company and been asked to write

15 their IFU; correct?

16 A. Only read them, not write

17 them.

18 Q. You've only -- you've never

19 worked for FDA and been asked to review

20 IFUs; correct?

21 A. I've not.

22 Q. Do you know of any

23 regulation with regard to what is

24 required by a manufacturer when drafting

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1 and finalizing an IFU?

2 A. No.

3 Q. You are citing to an AMA
4 informed consent requirement and that's
5 8.08; is that correct?

6 A. Yes.

7 Q. And what does that relate to
8 generally?

9 A. That's a policy regarding
10 informed consent.

11 Q. Does that require doctors
12 and physicians to give informed consent
13 to their patients?

14 A. Correct.

15 Q. That's not a regulation that
16 is placed upon manufacturers; correct?

17 A. Well, no, not directly.

18 Q. And you agree with me that
19 the doctor is required to inform the
20 patient; correct?

21 A. Correct.

22 Q. You've read Dr. DeLeary's
23 transcript; correct?

24 A. I did.

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1 Q. And you know that he states
2 that he was aware that dyspareunia was a
3 potential risk at the time he implanted
4 the TVT; correct?

5 MS. SANTRA: Object to form.

6 THE WITNESS: Yes.

7 BY MS. ROBINSON:

8 Q. He was aware that scarring
9 could be a part of that; is that correct?

10 MS. SANTRA: Object to form.

11 THE WITNESS: Yes.

12 BY MS. ROBINSON:

13 Q. He was aware that voiding
14 dysfunction could occur; is that correct?

15 MS. SANTRA: Object to form.

16 THE WITNESS: Yes.

17 BY MS. ROBINSON:

18 Q. He was aware that those
19 conditions could be mild, severe;
20 correct?

21 MS. SANTRA: Object to form.

22 THE WITNESS: Yes.

23 BY MS. ROBINSON:

24 Q. That they could be short

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1 term or long term; is that correct?

2 MS. SANTRA: Object to form.

3 THE WITNESS: Correct.

4 BY MS. ROBINSON:

5 Q. Doctor, with regard to your
6 testimony about the mesh contracture, can
7 you testify to a reasonable degree of
8 medical certainty having not seen her
9 mesh that it -- that the mesh itself
10 actually contracted?

11 A. Yes.

12 Q. And what's that based on?

13 A. Well, it's based primarily
14 on my physical exam findings, which
15 indicated some tautness and tightness to
16 the area where the sling was located.

17 Q. And that makes you think
18 that the mesh itself contracted or simply
19 that there was wound contracture?

20 A. Well, really, typically,
21 it's a combination of both.

22 Q. Can you tell me what degree
23 it contracted?

24 A. Well, that's very difficult

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1 to do in the absence of histological or
2 electron micrograph-type specimens.

3 Q. When did you last implant a
4 polypropylene mesh?

5 A. About three weeks ago.

6 Q. If that patient develops
7 dyspareunia in the future, do you believe
8 it's caused by a defect in the mesh?

9 MS. SANTRA: Object to form.

10 THE WITNESS: Well, I think
11 that's a difficult question to
12 answer because I think to some
13 degree it depends on, number one,
14 which kind of mesh and, secondly,
15 it would depend to some degree on
16 why the patient is having the
17 dyspareunia; in other words, is it
18 something I would attribute to, in
19 this example, the sling or
20 something else.

21 BY MS. ROBINSON:

22 Q. Well, let's back up for a
23 second then and let's say the type of
24 mesh that you currently use is a type 1

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1 lightweight macroporous mesh; correct?

2 A. Yes.

3 Q. And TVT is a type 1

4 lightweight macroporous mesh; correct?

5 A. Yes.

6 Q. Have you ever sat down to
7 compare those two types of meshes side to
8 side?

9 A. Only holding them in my hand
10 type comparisons, not more sophisticated
11 comparisons.

12 Q. You've never studied them.
13 Right?

14 A. Not in depth like a
15 molecular or biomechanical type of person
16 might, no.

17 Q. And --

18 MS. SANTRA: I think time is
19 up, Susan.

20 BY MS. ROBINSON:

21 Q. You're not testifying that
22 that mesh is an alternative to the TVT
23 mesh; is that correct?

24 MS. SANTRA: I'm going to

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1 instruct him not to answer the
2 question because time is up.

3 MS. ROBINSON: All right.
4 Go ahead.

5 MS. SANTRA: I actually need
6 just a two-minute break, if that's
7 all right, so we're going to go
8 off the record for a minute.

9 (A recess was taken from
10 11:11 a.m. until 11:15 a.m.)

11 - - -

12 EXAMINATION

13 - - -

14 BY MS. SANTRA:

15 Q. Dr. Walmsley, you performed
16 a differential diagnosis when coming to
17 your opinions about Ms. Ward; is that
18 correct?

19 A. Yes, ma'am.

20 Q. And when you were performing
21 your differential diagnosis, did you take
22 into account her other medical
23 conditions?

24 A. Yes, I did.

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1 Q. And I'll just -- I have a
2 list, but did you take into account her
3 past -- or history of infertility, kidney
4 stones, anxiety, panic attacks,
5 migraines, lumbar back pain, abdominal
6 pain, hiatal hernia, constipation, and
7 weight gain of about 48 pounds when you
8 were performing your differential
9 diagnosis on Ms. Ward?

10 A. Yes.

11 MS. ROBINSON: Object to
12 form.

13 BY MS. SANTRA:

14 Q. And considering all her --
15 all of those other medical conditions,
16 did you still come to the conclusion that
17 the TVT was a cause for her pelvic pain
18 and dyspareunia?

19 A. Yes.

20 MS. ROBINSON: Object to
21 form.

22 BY MS. SANTRA:

23 Q. And did you still come to
24 the conclusion to a reasonable degree of

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1 medical certainty that her TVT was a
2 cause for her urinary dysfunction?

3 A. Yes.

4 Q. And when you were performing
5 your differential diagnosis for Ms. Ward,
6 did you take into account her surgical
7 history?

8 A. I did.

9 Q. And that included a
10 hysterectomy in 1991, kidney stones in
11 1996, cholecystectomy, a D & C in 2006 --

12 MS. ROBINSON: Object to the
13 form.

14 BY MS. SANTRA:

15 Q. -- and a -- I'm sorry.
16 Strike that. Let me start over with
17 that.

18 Ms. Ward's surgical history
19 included kidney stones, a
20 cholecystectomy, a D & C, and a
21 laparoscopically assisted vaginal
22 hysterectomy with BSO; is that correct?

23 A. Correct.

24 Q. And did you take into

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1 account her entire surgical history when
2 you performed your differential
3 diagnosis?

4 A. Yes.

5 MS. ROBINSON: Object to
6 form.

7 BY MS. SANTRA:

8 Q. And did you still come to
9 the conclusion that the TVT mesh was a
10 cause for her injuries today?

11 A. Yes.

12 MS. ROBINSON: Object to
13 form. I'm sorry. I don't mean to
14 -- Hayleigh, I don't mean to get
15 you off track. I'm just having a
16 hard time getting my objection in
17 before the doctor speaks.

18 MS. SANTRA: Sure. That's
19 fine.

20 BY MS. SANTRA:

21 Q. I want to go to your opinion
22 concerning the IFU. I think that's your
23 general opinion number 1; correct?

24 A. Yes.

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1 Q. And what is your experience
2 with IFUs?

3 A. I use IFUs in gaining
4 experience about medical devices and
5 procedures relating to those devices. I
6 rely upon it to help me not only guide me
7 technically with the procedure, but allow
8 me to understand the indications,
9 contraindications, and potential
10 complications relating to the use of the
11 medical device.

12 Q. And so does your opinion on
13 the TVT's IFU as of 2005 come from your
14 experience with IFUs as a practicing
15 urologist who relies on IFUs for medical
16 devices --

17 MS. ROBINSON: Object to
18 form.

19 BY MS. SANTRA:

20 Q. -- every day in your
21 practice or regularly in your practice?

22 A. Yes.

23 Q. And early on in the
24 deposition, counsel was asking you what

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1 you knew as far as complications from the
2 TVT in 2005. Do you remember those
3 questions?

4 A. Yes.

5 Q. And can you explain your
6 opinion as to why you think the warnings
7 or the adverse reactions that were put in
8 the IFU in 2005 were inadequate to inform
9 doctors about the true risks of the TVT?

10 A. Certainly. I think the
11 first is in the types, quantitatively the
12 different types, of adverse reactions
13 that can be expected, number one. And
14 then, number two, the nature,
15 significance, chronicity, and/or severity
16 of those adverse reactions as it relates
17 to the fact that some of them are
18 specifically mesh related.

19 Q. And so in 2005, if someone
20 understood that there may have been a
21 possibility for pain with the TVT
22 implant, does their understanding as to
23 the nature and chronicity and character
24 of that pain matter? Does that make

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1 sense?

2 A. Yes.

3 MS. ROBINSON: Object to
4 form.

5 THE WITNESS: Yes, and to
6 that end, having pelvic pain after
7 any incontinence procedure, yes,
8 that's an expectation. That being
9 said, when using synthetic mesh as
10 a means of performing that
11 antiincontinence procedure, the
12 pelvic pain that is inherently
13 related to the mesh is actually
14 quite different from the pelvic
15 pain one might expect from, let's
16 say, a nonmesh-related
17 antiincontinence surgery.

18 So I think that for an
19 antiincontinence surgery to read
20 about pelvic pain from a
21 mid-urethral sling, for example,
22 he or she may be drawing a
23 conclusion that, oh, well, this is
24 the typical kind of pain that I

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1 would expect after, let's say, an
2 autologous fascial sling procedure
3 or a Burch procedure, where in
4 fact it's different simply because
5 the kind of pain that mesh can
6 induce is different.

7 BY MS. SANTRA:

8 Q. And we were talking about
9 your examination of Ms. Ward in that you
10 said if you were treating her as a
11 treating physician, you may order a
12 urodynamic study if you were to see her
13 again; is that right?

14 A. I would consider it, yes.

15 Q. Could you treat Ms. Ward
16 without doing a urodynamic study if she
17 was your patient?

18 A. Yeah, I probably would, in
19 fact, treat her in anticipation or before
20 a urodynamic study.

21 Q. And so even without doing
22 that urodynamic study, you're confident
23 that you have enough information to
24 render your opinions about Ms. Ward to a

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1 reasonable degree of medical certainty?

2 A. That's correct.

3 Q. And you also had talked
4 about the fact that you performed a cough
5 stress test of Ms. Ward; is that correct?

6 A. I did, albeit not typically,
7 because typically, a cough stress test is
8 done when the bladder's full. In the
9 instance of Mrs. Ward, I was doing the
10 cough stress test primarily to see if
11 there was any urethral hypermobility.

12 Because her bladder only had
13 15 cc's in it, even if she really did
14 have genuine stress incontinence, it
15 might be harder to elicit incontinence
16 with a patient lying down on her back
17 with not much urine within her bladder.

18 Q. So the fact that she did --
19 she had a negative cough stress test on a
20 day that she went to see you when she
21 didn't have a lot of urine in her
22 bladder, that does not mean that she has
23 no recurrent stress urinary incontinence;
24 is that correct?

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1 A. That's correct.

2 Q. When you were performing
3 your differential diagnosis of Ms. Ward's
4 overactive bladder, did you consider
5 other factors such as her caffeine
6 intake, her weight, her lifestyle, the
7 fact that it could be idiopathic, the
8 fact that she has a history of
9 constipation, and her diabetes?

10 A. I did.

11 Q. And did you still conclude
12 that the TVT is a cause of her overactive
13 bladder symptoms?

14 MS. ROBINSON: Object to
15 form.

16 THE WITNESS: Yes.

17 BY MS. SANTRA:

18 Q. And how do you know that or
19 how did you rule the TVT in?

20 A. Well, in large part, because
21 that the complaints of her voiding
22 dysfunction occurred in a temporal
23 fashion, consistent with TVT-related
24 issues.

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1 For example, the TVT
2 undergoes a shrinkage and a contraction.
3 That in part is the mesh; that in part is
4 wound contraction. And that over time,
5 the fact that she went from actually
6 having benefit from the TVT as far as
7 voiding dysfunction to then developing
8 significant voiding dysfunction certainly
9 is very supportive of the TVT as being a
10 causative factor.

11 I wouldn't, to the points
12 made earlier, rule out other issues. For
13 example, the fact that she's gained
14 weight would certainly contribute to
15 that, less likely the constipation which
16 she had both before and after her
17 surgeries. And the diabetes, I wouldn't
18 weight necessarily as heavily only
19 because it's only been ongoing for
20 several years.

21 So I wouldn't necessarily
22 rule out other causes entirely as
23 contributing to her voiding dysfunction,
24 but certainly from a time course

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1 standpoint and clinically, based on the
2 kind of incontinence she has, which is
3 mixed incontinence, which is typically
4 the kind of voiding dysfunction one can
5 see as a complication of TVT, it's
6 certainly a cause.

7 Q. And in your differential
8 diagnosis for Ms. Ward's pelvic pain, did
9 you consider her history of constipation,
10 endometritis, ovarian cysts, and her
11 other surgeries?

12 A. Yes.

13 Q. And you still came to the
14 conclusion that the TVT is a cause for
15 her pelvic pain?

16 A. Correct.

17 Q. And -- and specifically
18 about the endometritis, you said you
19 couldn't rule it out up until she had a
20 hysterectomy?

21 A. Correct.

22 Q. Can you explain that?

23 A. So there's no evidence of
24 her having any aberrant endometrial

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1 tissue outside of her cervix, uterus, and
2 fallopian tubes, and ovaries for that
3 matter. As a result, and moreover, she
4 had her -- after her hysterectomy, her
5 pelvic pain was no better or no worse.

6 So it leads me to conclude
7 that, first off, there's no endometrial
8 tissue remaining to cause any sort of
9 endometritis-related pain, number one,
10 and, number two, the fact that her
11 surgery really had no impact on it
12 suggests to me that the surgery itself
13 was not -- the hysterectomy, that is -- a
14 causative factor as it relates to her
15 pelvic pain.

16 Q. And your examination and
17 interview of Ms. Ward, did you conduct
18 those the same way you would conduct them
19 for any patient who's coming into your
20 office?

21 A. Yes.

22 MS. ROBINSON: Object to
23 form.

24 BY MS. SANTRA:

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1 Q. And so the fact that the
2 litigation is ongoing had no effect on
3 your -- your examination or interview or
4 the way you conducted those; is that
5 correct?

6 A. That's correct.

7 MS. ROBINSON: Object to
8 form.

9 BY MS. SANTRA:

10 Q. Regarding your pelvic exam
11 of Ms. Ward, you reproduced Ms. Ward's
12 pain on pelvic exam with your two
13 fingers; is that correct?

14 A. Correct.

15 MS. ROBINSON: Object to
16 form.

17 BY MS. SANTRA:

18 Q. Would the activity during
19 sex of the husband's penis be, for lack
20 of a better word, would that be more
21 vigorous or -- than your exam?

22 A. Yes.

23 MS. ROBINSON: Object to
24 form.

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1 THE WITNESS: I would think
2 so, yes.

3 BY MS. SANTRA:

4 Q. And so from the fact that
5 upon your exam with your two fingers Ms.
6 Ward had pain in the -- in the vaginal
7 sulci, does that lead you to conclude
8 that she would also have that pain upon
9 intercourse?

10 MS. ROBINSON: Object to
11 form.

12 THE WITNESS: Yes.

13 BY MS. SANTRA:

14 Q. And can you say that to a
15 reasonable degree of medical certainty?

16 A. I can.

17 Q. Going to your case-specific
18 opinions, you mention two things, scar
19 plate and contraction/shrinkage as it
20 relates to Ms. Ward.

21 First, how do you know that
22 a scar plate formed with Ms. Ward's TVT?

23 A. Based on my physical
24 examination and the fact that when I

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1 examined her, she had indurating tissue
2 around and extending up to the vaginal
3 sulci where her sling was located. That
4 was the scar plate that I discuss in my
5 report.

6 Q. And then what evidence did
7 you find that there was contraction or
8 shrinkage of Ms. Ward's TVT?

9 A. So that was based on the
10 appreciation of the sling in certain
11 areas feeling taut or tense to my
12 palpation.

13 Once again, that is a
14 shrinkage that I attribute both to the
15 mesh itself contracting, but also to
16 there being some degree of wound
17 contraction as well.

18 Q. And this -- the scar plate
19 and shrinkage and contraction of the TVT
20 is what is contributing to Ms. Ward's
21 pelvic pain and dyspareunia; is that
22 right?

23 A. Correct.

24 MS. ROBINSON: Object to

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1 form.

2 BY MS. SANTRA:

3 Q. And does the scar plate
4 formation and the contraction or
5 shrinkage of the TVT also contributing to
6 Ms. Ward's urinary issues?

7 A. Yes.

8 MS. ROBINSON: Object to
9 form.

10 BY MS. SANTRA:

11 Q. Counsel asked you earlier
12 about whether there was chronic
13 inflammation. Do you remember that
14 question?

15 A. I do.

16 Q. How do you know that Ms.
17 Ward has chronic inflammation of her
18 tissue?

19 A. Well, I think, to be fair,
20 the best way to demonstrate that would be
21 to literally remove the mesh and examine
22 it pathologically, during which time, if
23 there were chronic inflammation, you'd
24 see that identified. You'd see a foreign

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1 body response to the mesh-based material.

2 So my conclusion that
3 there's chronic inflammation is based on
4 my physical exam and the fact that there
5 is a scar plate that is present that
6 continues to be tender on examination,
7 which to me is consistent with a chronic
8 inflammatory process.

9 Q. And are you basing that on
10 your clinical experience in treating
11 women like Ms. Ward and your knowledge of
12 the medical literature?

13 A. Yes.

14 MS. ROBINSON: Object to
15 form.

16 BY MS. SANTRA:

17 Q. Counsel asked you whether
18 the TVT was a cause for or contributing
19 to Ms. Ward's UTIs. Do you remember
20 that?

21 A. I do.

22 Q. And I think you said you
23 think it is a cause for her UTIs. Can
24 you explain that?

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1 MS. ROBINSON: Wait. I'm
2 going to object to this. I'm
3 going to object to this being
4 outside the scope of his opinions
5 he's rendered in his report --

6 MS. SANTRA: Well, if he --

7 MS. ROBINSON: -- on Mrs.
8 Ward.

9 I mean, nowhere in the four
10 corners of his report does he
11 relate UTIs to her TVT as being a
12 potential injury she sustained as
13 a result of the TVT. And I'm
14 going to object. It's outside the
15 scope and we are limiting him to
16 the four corners of his report.

17 MS. SANTRA: On the last
18 page of his report, he
19 specifically reserves the right to
20 supplement and amend his opinions,
21 and the point of this deposition
22 is to -- is to clarify and explore
23 his opinions as to Ms. Ward.

24 If you don't want to

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1 question him on it, that's fine,
2 but I would like for him to state
3 his opinion as to her UTIs on the
4 record.

5 MS. ROBINSON: I absolutely
6 and totally disagree with that.
7 If he wants to supplement his
8 opinions, he can do it with a
9 supplemental report, which we will
10 then take to the court and state
11 it's out of bounds.

12 There is no new information
13 that he has that calls for any
14 supplementation of his opinions.
15 He had all of the information
16 necessary to render a full report
17 at the time he filed the report
18 and I object to you trying to
19 expand the scope of his opinions
20 during this deposition during your
21 direct examination.

22 MS. SANTRA: He's gotten new
23 medical records and new
24 depositions have been taken since

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1 the reporting of his report on
2 July 8th so --

3 MS. ROBINSON: If you look
4 at his report as it is written, he
5 has documented on the occasions
6 where he has reported UTIs. He
7 has sufficient information. He
8 could have rendered that opinion
9 before.

10 And I'm not -- I mean, I
11 absolutely object to you exploring
12 this area with him. It is outside
13 the scope of his report and I
14 object to any attempt at this
15 deposition to expand his opinions.

16 MS. SANTRA: Well, we may
17 issue a supplemental report, and I
18 guess we'll leave the deposition
19 open if you all want to depose him
20 on that.

21 MS. ROBINSON: We'll just
22 have to take that up later, but I
23 was not prepared to depose him on
24 that because it's not part of his

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1 opinions.

2 MS. SANTRA: I'm going to

3 move on.

4 BY MS. SANTRA:

5 Q. On your reliance list, you

6 have included the materials in and

7 reviewed for the TVT general causation

8 reports; is that right?

9 A. Yes.

10 Q. And you have also relied on

11 the TVT general causation report issued

12 in this case just in general as

13 background for your case-specific

14 opinions in this case; is that correct?

15 A. Yes.

16 Q. And isn't it true that

17 Ethicon puts in their 2015 instructions

18 for use for the TVT that the TVT can

19 cause acute and/or chronic pain in the

20 groin, thigh, leg, pelvic, and/or

21 abdominal area?

22 MS. ROBINSON: Object to

23 form.

24 THE WITNESS: That's

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1 correct.

2 BY MS. SANTRA:

3 Q. And that the TVT can cause
4 pain with intercourse that may not
5 resolve?

6 MS. ROBINSON: Object to
7 form.

8 THE WITNESS: That's
9 correct.

10 BY MS. SANTRA:

11 Q. And that the TVT can cause
12 acute and/or chronic pain?

13 MS. ROBINSON: Object to
14 form.

15 THE WITNESS: Yes.

16 BY MS. SANTRA:

17 Q. And that the TVT can cause
18 voiding dysfunction.

19 MS. ROBINSON: Object to
20 form.

21 THE WITNESS: Yes.

22 MS. SANTRA: I think that's
23 all I have for you. Thank you,
24 Doctor.

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1 THE WITNESS: Thank you.

2 MS. ROBINSON: Thank you,

3 Doctor.

4 THE WITNESS: Thank you.

5 (Witness excused.)

6 (Deposition concluded at
7 approximately 11:42 a.m.)

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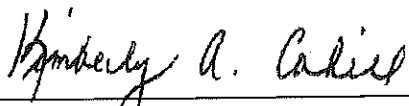
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Konstantin Walmsley, M.D.

CERTIFICATE

I HEREBY CERTIFY that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

It was requested before completion of the deposition that the witness, KONSTANTIN WALMSLEY, M.D., have the opportunity to read and sign the deposition transcript.


KIMBERLY A. CAHILL, a
Federally Approved Registered
Merit Reporter and Notary Public
Dated: August 15, 2016

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

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1 INSTRUCTIONS TO WITNESS

2

3 Please read your deposition
4 over carefully and make any necessary
5 corrections. You should state the reason
6 in the appropriate space on the errata
7 sheet for any corrections that are made.

8 After doing so, please sign
9 the errata sheet and date it.

10 You are signing same subject
11 to the changes you have noted on the
12 errata sheet, which will be attached to
13 your deposition.

14 It is imperative that you
15 return the original errata sheet to the
16 deposing attorney within thirty (30) days
17 of receipt of the deposition transcript
18 by you. If you fail to do so, the
19 deposition transcript may be deemed to be
20 accurate and may be used in court.

21

22

23

24

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2

ACKNOWLEDGMENT OF DEPONENT

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I, _____, do

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hereby certify that I have read the

6

foregoing pages, 1 - 146, and that the

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same is a correct transcription of the

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answers given by me to the questions

9

therein propounded, except for the

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corrections or changes in form or

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substance, if any, noted in the attached

12

Errata Sheet.

13

14

15

16

KONSTANTIN WALMSLEY, M.D.

DATE

17

18

19

Subscribed and sworn

to before me this

20

_____ day of _____, 20____.

21

My commission expires: _____

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Notary Public

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1	LAWYER'S NOTES		
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